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ABSTRACT

This document contains the text of a Congressional oversight hearing on Public Law 98-621, the St. Elizabeths Hospital and District of Columbia Mental Health Services Act, which became law in November 1984 and which transferred St. Elizabeths Hospital from federal control to that of the government of the District of Columbia. The text of Public Law 98-621 is included. An opening statement by Congressman Walter Fauntroy and a staff summary of findings and conclusions are given. Witnesses providing testimony include: (1) Wilford Forbush, director, Office of Management, Public Health Service, United States Department of Health and Human Services; (2) David Rivers, director, Department of Human Services, Government of the District of Columbia; (3) Virginia Fleming, director, Mental Health Systems Reorganization Office, Department of Human Services, Government of the District of Columbia; (4) Polly Shackleton, Council of the District of Columbia; (5) Steven Sharfstein, deputy medical director, American Psychiatric Association; (6) William Carr, District of Columbia Psychological Association and American Psychological Association; (7) Peggy Brown, legislative affairs specialist, American Federation of State, County, and Municipal Employees; (8) Leonard Stein, Dixon Implementation Monitoring Committee; and (9) Norman Rosenberg, director, Mental Health Law Project. Witnesses provide an oversight of the progress being made toward implementation of Public Law 98-621. Prepared statements are included from the National Federation for Biblio/Poetry Therapy, Physician's Association of St. Elizabeths Hospital, and the Medical Society of the District of Columbia. Other materials submitted for the record and communications are provided. (NB)

# IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT—PUBLIC LAW 98–621

## OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

OF THE

## COMMITTEE ON THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

ON

THE ASSUMPTION OF SELECTED FUNCTIONS, PROGRAMS, AND RESOURCES OF ST. ELIZABETHS HOSPITAL BY THE DISTRICT OF COLUMBIA

MAY 22, 1986

**Serial No. 99–20**

Printed for the use of the Committee on the District of Columbia

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## ACKNOWLEDGMENT

The subcommittee wishes to acknowledge Mr. Johnny Barnes, senior staff counsel, and Mr. Ronald C. Willis, staff assistant, for their continued fine work in the oversight of Public Law 98-621 and for their preparation of this hearing.

## STAFF SUMMARY OF FINDINGS AND CONCLUSIONS

In accordance with section 4(b)(1), of Public Law 98-621, the St. Elizabeths Hospital and District of Columbia Mental Health Services Act, the Subcommittee on Fiscal Affairs and Health of the Committee on the District of Columbia held oversight hearings on the progress being made toward the implementation of the aforementioned law. The subcommittee took oral and written testimony from a wide range of witnesses regarding the District's ability to carry out the legislative mandate of having in place by October 1991, a comprehensive mental health care system of which St. Elizabeths Hospital is an integral part. Central to the legislation was the court mandated Dixon implementation plan, which called for the outplacing of St. Elizabeths Hospital patients into community facilities in an orderly and timely manner. The plan, the result of a class-action suit brought on behalf of Mr. Dixon and other St. Elizabeths Hospital patients, is called for in section 4(b)(4) of Public Law 98-621. The committee is determining compliance with Public Law 98-621. Of particular concern to the representative of the Dixon Plan Monitoring Committee, was the District's ability to carry out the legislative mandate and their willingness to correct those areas not now in compliance with the Dixon plan as decreed by Judge Robinson. While the representatives from the District testified that there were certain areas of the comprehensive plan which could be amended, they felt that the overall plan was sound and could be implemented as submitted to the Congress.

The committee staff examination of the plan concludes that it does satisfy the legislative mandate both in form and in order and in the timetable set for the completion of the St. Elizabeths Hospital transfer process. Those areas of concern expressed by hearing witnesses will continue to be problem areas until the new system is in place. It is the opinion of the committee staff that the areas of concern can be corrected by the District Mental Health Reorganization Office, if an all out concerted effort is begun. However, the effort must begin now and should include the representatives from those agencies expressing disapproval of the plan as presented at the hearing.

# PUBLIC LAW 98-621, THE ST. ELIZABETHS HOSPITAL AND DISTRICT OF COLUMBIA MENTAL HEALTH SERVICES ACT

THURSDAY, MAY 22, 1986

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10 a.m., in room 1310, Longworth House Office Building, Hon. Walter E. Fauntroy (chairman of the subcommittee) presiding.

Present: Representative Fauntroy.

Also present: Edward C. Sylvester, Jr., staff director; Ronald C. Willis, staff assistant; Johnny Barnes, senior staff counsel; Stephanie White, minority staff counsel; and Shahid Z. Abdullah, minority staff assistant.

[The text of Pubic Law 98-621 follows:]

Public Law 98-621
98th Congress

# An Act

To provide for the assumption of selected functions, programs, and resources of Saint Elizabeths Hospital by the District of Columbia, to provide for the establishment of a comprehensive mental health care system in the District of Columbia, and for other purposes.

Nov. 8, 1984
[H.R. 6224]

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

Saint Elizabeths Hospital and District of Columbia Mental Health Services Act.
24 USC 225 note.

## SHORT TITLE

SECTION 1. This Act may be cited as the "Saint Elizabeths Hospital and District of Columbia Mental Health Services Act".

## FINDINGS AND PURPOSES

24 USC 225.

SEC. 2. (a) The Congress makes the following findings:

(1) Governmentally administered mental health services in the District of Columbia are currently provided through two separate public entities, the federally administered Saint Elizabeths Hospital and the Mental Health Services Administration of the District of Columbia Department of Human Resources.

(2) The District of Columbia has a continuing responsibility to provide mental health services to its residents.

(3) The Federal Government, through its operation of a national mental health program at Saint Elizabeths Hospital, has for over 100 years assisted the District of Columbia in carrying out that responsibility.

(4) Since its establishment by Congress in 1855, Saint Elizabeths Hospital has developed into a respected national mental health hospital and study, training, and treatment center, providing a range of quality mental health and related services, including—

(i) acute and chronic inpatient psychiatric care;

(ii) outpatient psychiatric and substance abuse clinical and related services;

(iii) Federal court system forensic psychiatry referral, evaluation, and patient treatment services for prisoners, and for individuals awaiting trial or requiring post-trial or post-sentence psychiatric evaluation;

(iv) patient care and related services for designated classes of individuals entitled to mental health benefits under Federal law, such as certain members and employees of the United States Armed Forces and the Foreign Service, and residents of American overseas dependencies;

(v) District of Columbia court system forensic psychiatry referral, evaluation, and patient treatment services for prisoners, and for individuals awaiting trial or requiring post-trial or post-sentence psychiatric evaluation;

(vi) programs for special populations such as the mentally ill deaf;

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(vii) support for basic and applied clinical psychiatric research and related patient services conducted by the National Institute of Mental Health and other institutions; and

(viii) professional and paraprofessional training in the major mental health disciplines.

(5) The continuation of the range of services currently provided by federally administered Saint Elizabeths Hospital must be assured, as these services are integrally related to—

(i) the availability of adequate mental health services to District of Columbia residents, nonresidents who require mental health services while in the District of Columbia, individuals entitled to mental health services under Federal law, and individuals referred by both Federal and local court systems; and

(ii) the Nation's capacity to increase our knowledge and understanding about mental illness and to facilitate and continue the development and broad availability of sound and modern methods and approaches for the treatment of mental illness.

(6) The assumption of all or selected functions, programs, and resources of Saint Elizabeths Hospital from the Federal Government by the District of Columbia, and the integration of those functions, resources, and programs into a comprehensive mental health care system administered solely by the District of Columbia, will improve the efficiency and effectiveness of the services currently provided through those two separate entities by shifting the primary focus of care to an integrated community-based system.

Home rule.

(7) Such assumption of all or selected functions, programs, and resources of Saint Elizabeths Hospital by the District of Columbia would further the principle of home rule for the District of Columbia.

(b) It is the intent of Congress that—

(1) the District of Columbia have in operation no later than October 1, 1991, an integrated coordinated mental health system in the District which provides—

(A) high quality, cost-effective, and community-based programs and facilities;

(B) a continuum of inpatient and outpatient mental health care, residential treatment, and support services through an appropriate balance of public and private resources; and

(C) assurances that patient rights and medical needs are protected;

(2) the comprehensive District mental health care system be in full compliance with the Federal court consent decree in Dixon v. Heckler;

(3) the District and Federal Governments bear equitable shares of the costs of a transition from the present system to a comprehensive District mental health system;

Employment and unemployment.

(4) the transition to a comprehensive District mental health system provided for by this Act be carried out with maximum consideration for the interests of employees of the Hospital and provide a right-of-first-refusal to such employees for employment at comparable levels in positions created under the system implementation plan;

(5) the Federal Government have the responsibility for the retraining of Hospital employees to prepare such employees for the requirements of employment in a comprehensive District mental health system; Employment and unemployment.

(6) the Federal Government continue high quality mental health research, training, and demonstration programs at Saint Elizabeths Hospital; Research and development.

(7) the District government establish and maintain accreditation and licensing standards for all services provided in District mental health facilities which assure quality care consistent with appropriate Federal regulations and comparable with standards of the Joint Commission on Accreditation of Hospitals; and

(8) the comprehensive mental health system plan include a component for direct services for the homeless mentally ill.

DEFINITIONS

SEC. 3. For the purpose of this Act: 24 USC 225a.

(1) The term "Hospital" means the institution in the District of Columbia known as Saint Elizabeths Hospital operated on the date of the enactment of this Act by the Secretary of Health and Human Services.

(2) The term "Secretary" means the Secretary of Health and Human Services.

(3) The term "Mayor" means the Mayor of the District of Columbia.

(4) The term "District" means the District of Columbia.

(5) The term "Federal court consent decree" means the consent decree in Dixon v. Heckler, Civil Action No. 74-285.

(6) The term "service coordination period" means a period beginning on the effective date of this Act and terminating on October 1, 1987.

(7) The term "financial transition period" means a period beginning on the effective date of this Act and terminating on October 1, 1991.

(8) The term "system implementation plan" means the plan for a comprehensive mental health system for the District of Columbia to be developed pursuant to this Act.

(9) The term "Council" means the Council of the District of Columbia.

DEVELOPMENT OF PLAN FOR MENTAL HEALTH SYSTEM FOR THE DISTRICT

SEC. 4. (a)(1) Subject to subsection (g) of this section and section 9(b)(1), effective October 1, 1987, the District shall be responsible for the provision of mental health services to residents of the District. 24 USC 225b.

(2) Not later than October 1, 1991, the Mayor shall complete the implementation of the final system implementation plan reviewed by the Congress and the Council in accordance with the provisions of this Act for the establishment of a comprehensive District mental health system to provide mental health services and programs through community mental health facilities to individuals in the District of Columbia.

(b)(1) The Mayor shall prepare a preliminary system implementation plan for a comprehensive mental health system no later than 3

months from the effective date of this Act, and a final implementation plan no later than 12 months from the effective date of this Act.

(2) The Mayor shall submit the preliminary system implementation plan to the Council no later than 3 months from the effective date of this Act. The Council shall review such plan and transmit written recommendations to the Mayor regarding any revisions to such plan no later than 60 days after such submission. The Mayor shall submit the revised preliminary plan to the Committee on the District of Columbia of the House of Representatives and the Committee on Labor and Human Resources and the Committee on Governmental Affairs of the Senate for review and comment in accordance with the provisions of this Act.

(3) The final system implementation plan shall be considered by the Council consistent with the provisions of section 422(12) of the District of Columbia Self-Government and Governmental Reorganization Act.

87 Stat. 790.

(4) After the review of the Council pursuant to paragraph (3), the Mayor shall submit the final implementation plan to the Committee on the District of Columbia of the House of Representatives and the Committee on Labor and Human Resources and the Committee on Governmental Affairs of the Senate for review and comment in accordance with the provisions of this Act.

(c) The system implementation plan shall—

(1) propose and describe an integrated, comprehensive, and coordinated mental health system for the District of Columbia;

(2) identify the types of treatment to be offered, staffing patterns, and the proposed sites for service delivery within the District of Columbia comprehensive mental health system;

(3) identify mechanisms to attract and retain personnel of appropriate number and quality to meet the objectives of the comprehensive mental health system;

(4) be in full compliance with the Federal court consent decree in Dixon v. Heckler and all applicable District of Columbia statutes and court decrees;

(5) identify those positions, programs, and functions at Saint Elizabeths Hospital which are proposed for assumption by the District, those facilities at Saint Elizabeths Hospital which are proposed for utilization by the District under a comprehensive District mental health system, and the staffing patterns and programs at community facilities to which the assumed functions are to be integrated;

(6) identify any capital improvements to facilities at Saint Elizabeths Hospital and elsewhere in the District of Columbia proposed for delivery of mental health services, which are necessary for the safe and cost effective delivery of mental health services; and

(7) identify the specific real property, buildings, improvements, and personal property to be transferred pursuant to section 8(a)(1) of this Act needed to provide mental health and other services provided by the Department of Human Services under the final system implementation plan.

(d)(1) The Mayor shall develop the system implementation plan in close consultation with officials of Saint Elizabeths Hospital, through working groups to be established by the Secretary and the Mayor for that purpose.

Labor-management advisory committee, establishment.

(2) The Mayor and the Secretary shall establish a labor-management advisory committee, requesting the participation of Federal

and District employee organizations affected by this Act, to make recommendations on the system implementation plan. The committee shall consider staffing patterns under a comprehensive District mental health care system, retention of Hospital employees under such system, Federal retraining for such employees, and any other areas of concern related to the establishment of a comprehensive District system. In developing the system implementation plan the Mayor shall carefully consider the recommendations of the committee. Such advisory committee shall not be subject to the Federal Advisory Committee Act. 5 USC app.

(3) The Mayor and such working groups shall, in developing the plan, solicit comments from the public, which shall include professional organizations, provider agencies and individuals, and mental health advocacy groups in the District of Columbia.

(e)(1) The Mayor and the Secretary may, during the service coordination period, by mutual agreement and consistent with the requirements of the system implementation plan direct the shift of selected program responsibilities and staff resources from Saint Elizabeths Hospital to the District. The Secretary may assign staff occupying positions in affected programs to work under the supervision of the District. The Mayor shall notify the Committee on the District of Columbia of the House of Representatives and the Committee on Labor and Human Resources and the Committee on Governmental Affairs of the Senate in writing of any planned shift in program responsibilites or staff resources not less than 30 days prior to the implementation of such shift.

(2)(A) Except as provided in subparagraph (B), after October 1, 1984, and during the service coordination period, no request for proposals may be issued by the Secretary for any areas of commercial activity at the Hospital pursuant to Office of Management and Budget circular A-76. Prohibition.

(B) The limitation under subparagraph (A) shall not apply to studies initiated pursuant to such circular prior to October 1, 1984.

(f)(1) To assist the Mayor in the development of the system implementation plan, the Secretary shall contract for a financial audit and a physical plant audit of all existing facilities at the Hospital to be completed by January 1, 1986. The financial audit shall be conducted according to generally accepted accounting principles. The physical plant audit shall recognize any relevant national and District codes and estimate the useful life of existing facility support systems. Audit.

(2)(A) Pursuant to such physical plant audit, the Secretary shall initiate not later than October 1, 1987, and complete not later than October 1, 1991, such repairs and renovations to such physical plant and facility support systems of the Hospital as are to be utilized by the District under the system implementation plan as part of a comprehensive District mental health system, as are necessary to meet any applicable code requirements or standards.

(B) At a minimum until October 1, 1987, the Secretary shall maintain all other facilities and infrastructure of the Hospital not assumed by the District in the condition described in such audit.

(g) During the service coordination period, the District of Columbia and the Secretary, to the extent provided in the Federal court consent decree, shall be jointly responsible for providing citizens with the full range and scope of mental health services set forth in such decree and the system implementation plan. No provision of this Act or any action or agreement during the service coordination

period may be so construed as to absolve or relieve the District or the Federal Government of their joint or respective responsibilities to implement fully the mandates of the Federal court consent decree.

CONGRESSIONAL REVIEW OF SYSTEM IMPLEMENTATION PLAN

24 USC 225c.

SEC. 5. (a) The Committee on the District of Columbia of the House of Representatives and the Committee on Labor and Human Resources and the Committee on Governmental Affairs of the Senate shall review the preliminary system implementation plan transmitted by the Mayor pursuant to section 4 of this Act to determine the extent of its compliance with the provisions of section 2(b) and section 4 of this Act, and transmit written recommendations regarding any revisions to the preliminary plan to the Mayor not later than 60 days after receipt of such plan.

(b) The Committee on the District of Columbia of the House of Representatives and the Committee on Labor and Human Resources and the Committee on Governmental Affairs of the Senate shall, within 90 days of submission of the final system implementation plan by the Mayor pursuant to section 4 of this Act, review such plan to determine the extent to which it is in compliance with the provisions of section 2(b) and section 4 of this Act.

TRANSITION PROVISIONS FOR EMPLOYEES OF THE HOSPITAL

Retirement.
24 USC 225d.

SEC. 6. (a) Employees of the Hospital directly affected by the assumption of programs and functions by the District government who meet the requirements for immediate retirement under the provisions of section 8336(d) of title 5, United States Code, shall be accorded the opportunity to retire during the 30-day period prior to the assumption of such programs and functions.

(b)(1) The system implementation plan shall prescribe the specific number and types of positions needed by the District government at the end of the service coordination period.

(2) Notwithstanding section 3503 of title 5, United States Code, employees of the Hospital shall only be transferred to District employment under the provisions of this section.

(c)(1) While on the retention list or the District or Federal agency reemployment priority list, the system implementation plan shall provide to Hospital employees a right-of-first-refusal to District employment in positions for which such employees may qualify, (A) created under the system implementation plan in the comprehensive District mental health system, (B) available under the Department of Human Services of the District, and (C) available at the District of Columbia General Hospital.

(2) In accordance with Federal regulations, the Secretary shall establish retention registers of Hospital employees and provide such retention registers to the District government. Employment in positions identified in the system implementation plan under subsection (b) shall be offered to Hospital employees by the District government according to each such employee's relative standing on the retention registers.

(3) Employee appeals concerning the retention registers established by the Secretary shall be in accordance with Federal regulations.

(4) Employee appeals concerning employment offers by the District shall be in accordance with the District of Columbia Government Comprehensive Merit Personnel Act of 1978.

(d)(1) Notwithstanding any other provision of law, employees of the Hospital, while on the Federal agency reemployment priority list, shall have a right-of-first-refusal to employment in comparable available positions for which they qualify within the Department of Health and Human Services in the Washington metropolitan area.

(2) If necessary to separate employees of the Hospital from Federal employment, such employees may be separated only under Federal reduction-in-force procedures.

(3) A Federal agency reemployment priority list and a displaced employees program shall be maintained for employees of the Hospital by the Secretary and the Office of Personnel Management in accordance with Federal regulations for Federal employees separated by reduction-in-force procedures.

(4) The Mayor shall create and maintain, in consultation with the Secretary, a District agency reemployment priority list of those employees of the Hospital on the retention registers who are not offered employment under subsection (c). Individuals who refuse an offer of employment under subsection (c) shall be ineligible for inclusion on the District agency reemployment priority list. Such reemployment priority list shall be administered in accordance with procedures established pursuant to the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (D.C. Law 2-139).

(5) Acceptance of nontemporary employment as a result of referral from any retention list or agency reemployment priority list shall automatically terminate an individual's severance pay as of the effective date of such employment.

Contracts.

(e) Any contract entered into by the District of Columbia for the provision of mental health services formerly provided by or at the Hospital shall require the contractor or provider, in filling new positions created to perform under the contract, to give preference to qualified candidates on the District agency reemployment priority list created pursuant to subsection (d) of this section. An individual who is offered nontemporary employment with a contractor shall have his or her name remain on the District agency reemployment priority list under subsection (d) for not more than 24 months from the date of acceptance of such employment.

CONDITIONS OF EMPLOYMENT FOR FORMER EMPLOYEES OF THE HOSPITAL

24 USC 225e.

SEC. 7. (a) Each individual accepting employment without a break in service with the District government pursuant to section 6 shall—

(1) except as specifically provided in this Act, be required to meet all District qualifications other than licensure requirements for appointment required of other candidates, and shall become District employees in the comparable District service subject to the provisions of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, and all other statutes and regulations governing District personnel;

(2) meet all licensure requirements within 18 months of appointment by the District government;

5 USC 6301 *et seq.*

(3) notwithstanding chapter 63 of title 5, United States Code, transfer accrued annual and sick leave balances pursuant to

title XII of the District of Columbia Comprehensive Merit Personnel Act of 1978;

(4) have the grade and rate of pay determined in accordance with regulations established pursuant to title XI of the District of Columbia Comprehensive Merit Personnel Act of 1978, except that no employee shall suffer a loss in the basic rate of pay or in seniority;

(5) if applicable, retain a rate of pay including the physician's comparability allowance under the provisions of section 5948 of title 5, United States Code, and continue to receive such allowance under the terms of the then prevailing agreement until its expiration or for a period of 2 years from the date of appointment by the District government, whichever occurs later;

(6) be entitled to the same health and life insurance benefits as are available to District employees in the applicable service;

(7) if employed by the Federal Government before January 1, 1984, continue to be covered by the United States Civil Service Retirement System, under chapter 83 of title 5, United States Code, to the same extent that such retirement system covers District Government employees; and

5 USC 8301 *et seq.*

(8) if employed by the Federal Government on or after January 1, 1984, be subject to the retirement system applicable to District government employees pursuant to title XXVI, Retirement, of the District of Columbia Government Comprehensive Merit Personnel Act of 1978.

(b) An individual appointed to a position in the District government without a break in service, from the retention list, or from the District or Federal agency reemployment priority lists shall be exempt from the residency requirements of title VIII of the District of Columbia Government Comprehensive Merit Personnel Act of 1978.

(c) An individual receiving compensation for work injuries pursuant to chapter 81 of title 5, United States Code, shall—

5 USC 8101 *et seq.*

(1) continue to have the claims adjudicated and the related costs paid by the Federal Government until such individual recovers and returns to duty;

(2) if medically recovered and returned to duty, have any subsequent claim for the recurrence of the disability determined and paid under the provisions of title XXIII of the District of Columbia Comprehensive Merit Personnel Act of 1978.

(d) The District government may initiate or continue an action against an individual who accepts employment under section 6(c) for cause related to events that occur prior to the end of the service coordination period. Any such action shall be conducted in accordance with such Federal laws and regulations under which action would have been conducted had the assumption of function by the District not occurred.

(e) Commissioned public health service officers detailed to the District of Columbia mental health system shall not be considered employees for purposes of any full-time employee equivalency total of the Department of Health and Human Services.

(f) For purposes of this section, Hospital employees shall include former patient employees occupying career positions at the Hospital.

PROPERTY TRANSFER

SEC. 8. (a)(1) Except as provided in paragraph (2), on October 1, 1987, the Secretary shall transfer to the District, without compensation, all right, title, and interest of the United States in all real property at Saint Elizabeths Hospital in the District of Columbia together with any buildings, improvements, and personal property used in connection with such property needed to provide mental health and other services provided by the Department of Human Services indentified pursuant to section 4(c)(7) of this Act. Effective dates. 24 USC 225f.

(2) Such real property as is identified by the Secretary by September 30, 1987, as necessary to Federal mental health programs at Saint Elizabeths Hospital under section 2(b)(5) shall not be transferred under this subsection.

(b) On or before October 1, 1991, the Mayor shall prepare, and submit to the Committee on the District of Columbia of the House of Representatives and the Committees on Governmental Affairs and Labor and Human Resources of the Senate, a master plan, not inconsistent with the comprehensive plan for the National Capital, for the use of all real property, buildings, improvements, and personal property comprising Saint Elizabeths Hospital in the District of Columbia not transferred or excluded pursuant to subsection (a) of this section. In developing such plan, the Mayor shall consult with, and provide an opportunity for review by, appropriate Federal, regional, and local agencies. Such master plan submitted by the Mayor shall be approved by a law enacted by the Congress within the twelve-month period following the date such plan is submitted to the Committee on the District of Columbia of the House of Representatives and the Committees on Governmental Affairs and Labor and Human Resources of the Senate. Immediately upon the approval of any such law, the Secretary shall transfer to the District, without compensation, all right, title, and interest of the United States in and to such property in accordance with such approved plan. The real property, together with the buildings and other improvements thereon, including personal property used in connection therewith, known as the Oxon Cove Park and operated by the National Park Service, Department of the Interior, shall not be transferred under this Act. Development plan.

(c) On October 1, 1985, the Secretary shall transfer to the District, without compensation, all right, title, and interest of the United States to lot 87, square 622, in the subdivision made by the District of Columbia Redevelopment Land Agency, as per plat recorded in the Office of the Surveyor for the District of Columbia, in liber 154 at folio 149 (901 First Street N.W., the J.B. Johnson Building and grounds).

FINANCING PROVISIONS

SEC. 9. (a) There are authorized to be appropriated for grants by the Secretary of Health and Human Services to the District of Columbia comprehensive mental health system, $30,000,000 for fiscal year 1988, $24,000,000 for fiscal year 1989, $18,000,000 for fiscal year 1990, and $12,000,000 for fiscal year 1991. Appropriation authorization. Grants. 24 USC 225g.

(b)(1) Beginning on October 1, 1987, and in each subsequent fiscal year, the appropriate Federal agency is directed to pay the District of Columbia the full costs for the provision of mental health diagnostic and treatment services for the following types of patients:

(A) Any individual referred to the system pursuant to a Federal statute or by a responsible Federal agency.

(B) Any individual referred to the system for emergency detention or involuntary commitment after being taken into custody (i) as a direct result of the individual's action or threat of action against a Federal official, (ii) as a direct result of the individual's action or threat of action on the grounds of the White House or of the Capitol, or (iii) under chapter 9 of title 21 of the District of Columbia Code.

(C) Any individual referred to the system as a result of a criminal proceeding in a Federal court (including an individual admitted for treatment, observation, and diagnosis and an individual found incompetent to stand trial or found not guilty by reason of insanity). The preceding provisions of this paragraph apply to any individual referred to the system (or to Saint Elizabeths Hospital) before or after the date of enactment of this Act.

Compacts between States.

(2) The responsibility of the United States for the cost of services for individuals described in paragraph (1) shall not affect the treatment responsibilities to the District of Columbia under the Interstate Compact on Mental Health.

(c)(1) During the service coordination and the financial transition periods, the District of Columbia shall gradually assume a greater share of the financial responsibility for the provision of mental health services provided by the system to individuals not described in subsection (b).

(2) Section 502 of the District of Columbia Self-Government and Governmental Reorganization Act is amended—

87 Stat. 813.

(A) by inserting "(a)" after "SEC. 502.", and

(B) by adding at the end the following:

Appropriation authorization.

"(b)(1) Except as otherwise provided by paragraph (2), there are authorized to be appropriated, in addition to the amounts authorized to be appropriated under subsection (a), $25,000,000 for fiscal year 1986, $35,000,000 for fiscal year 1987, $30,000,000 for fiscal year 1988, $20,000,000 for fiscal year 1989, $15,000,000 for fiscal year 1990, and $10,000,000 for fiscal year 1991 to the District of Columbia for establishing and maintaining a comprehensive mental health system.

"(2) For each of the fiscal years 1986 through 1990 there is authorized to be appropriated, in addition to the amount authorized under paragraph (1), an amount equal to one-third of the amount authorized under paragraph (1) for the succeeding fiscal year. The amount authorized to be appropriated under paragraph (1) for any such succeeding fiscal year shall be reduced by the amount appropriated for the preceding fiscal year under the first sentence of this paragraph.".

(d) Subject to section 4(f)(2), capital improvements to facilities at Saint Elizabeths Hospital authorized during the service coordination period shall be the shared responsibility of the District and the Federal Government in accordance with Public Law 83-472.

68 Stat. 434.

(e) Pursuant to the financial audit under section 4(f), any unassigned liabilities of the Hospital shall be assumed by and shall be the sole responsibility of the Federal Government.

Audit.

(f)(1) After the service coordination period, the Secretary shall conduct an audit, under generally accepted accounting procedures, to identify the liability of the Federal Government for accrued

annual leave balances for those employees assumed by the District under the system implementation plan.

(2) There is authorized to be appropriated for payment by the Federal Government to the District an amount equal to the liability identified by such audit. Appropriation authorization.

(g) Nothing in this Act shall affect the authority of the District of Columbia under any other statute to collect costs billed by the District of Columbia for mental health services, except that payment for the same costs may not be collected from more than one party.

(h) The Government of the United States shall be solely responsible for— Claims.

(1) all claims and causes of action against Saint Elizabeths Hospital that accrue before October 1, 1987, regardless of the date on which legal proceedings asserting such claims were or may be filed, except that the United States shall, in the case of any tort claim, only be responsible for any such claim against the United States that accrues before October 1, 1987, and the United States shall not compromise or settle any claim resulting in District liability without the consent of the District, which consent shall not be unreasonably withheld; and

(2) all claims that result in a judgment or award against Saint Elizabeths Hospital before October 1, 1987.

REPEALS AND CONFORMING AMENDMENTS

SEC. 10. (a) Chapter 4 of title LIX of the Revised Statutes of the United States (24 U.S.C. 161, 165, 170, 191, 211, 211a, 211b, and 221, and D.C. Code 32-405 and 32-406) is repealed.

(b) The matter under the subheading "SAINT ELIZABETHS HOSPITAL." under the heading "DEPARTMENT OF THE INTERIOR." in the first section of an Act of June 5, 1920, chapter 235 of the laws of the second session of the 66th Congress, is amended by striking out the second sentence (24 U.S.C. 166). 41 Stat. 919.

(c) The matter under the subheading "SAINT ELIZABETHS HOSPITAL." under the heading "DEPARTMENT OF THE INTERIOR." in the first section of the Second Deficiency Appropriation Act, fiscal year 1920, is amended by striking out the second and third sentences (24 U.S.C. 168 and 176). 41 Stat. 513.

(d)(1) An Act of August 4, 1947, chapter 478 of the laws of the first session of the 80th Congress (24 U.S.C. 168a, 169, 169a, 185, and 195a), is repealed.

(2) The matter under the heading "Saint Elizabeths Hospital" in title II of the Departments of Labor, and Health, Education, and Welfare Appropriation Act, 1955, is amended by striking out all that follows "$110,000" before the period. 68 Stat. 437.

(e) The matter under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "UNDER THE DEPARTMENT OF THE INTERIOR." in the first section of an Act of August 24, 1912, chapter 355 of the laws of the second session of the 62d Congress, is amended by striking out the second sentence (24 U.S.C. 171). 37 USC 461.

(f) The first sentence under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "MISCELLANEOUS OBJECTS." in the first section of an Act of August 7, 1882, chapter 433 of the laws of the first session of the 47th Congress, is amended by striking out— 22 Stat. 329.

(1) "; and that hereafter the surplus products and waste material of the hospital may be sold or exchanged for the benefit of the hospital, and proceeds to be used and accounted for the same as its other funds:" (24 U.S.C. 172), and

(2) the two provisos (24 U.S.C. 165 and 195), and by inserting in lieu thereof a period.

(g) The matter under the subheading "SAINT ELIZABETHS HOSPITAL." and that subheading under the heading "DEPARTMENT OF THE INTERIOR." of the Act of April 17, 1917 (24 U.S.C. 175), are repealed.

40 Stat. 19.

(h) The matter under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "UNDER THE DEPARTMENT OF THE INTERIOR." in the first section of an Act of June 30, 1906, chapter 3914 of the laws of the first session of the 59th Congress, is amended by striking out the last three sentences (24 U.S.C. 177).

34 Stat. 730.

(i) An Act of May 9, 1941, chapter 101 of the laws of the first session of the 77th Congress (24 U.S.C. 180), is repealed.

55 Stat. 760.

(j) The Act of November 15, 1941 (24 U.S.C. 181, 182, 183, and 184) is repealed.

(k)(1) The matter under the heading "PAY, MISCELLANEOUS." of an Act of August 29, 1916, chapter 417 of the laws of the first session of the 64th Congress, is amended by striking out "Hereafter interned persons and prisoners of war, under the jurisdiction of the Navy Department, who are or may become insane, shall be entitled to admission for treatment to the Government Hospital for the Insane." (24 U.S.C. 192).

39 Stat. 557.

(2) The matter under the subheading "SAINT ELIZABETHS HOSPITAL." under the heading "DEPARTMENT OF THE INTERIOR." in the first section of an Act of October 6, 1917, chapter 79 of the laws of the first session of the 65th Congress, is amended by striking out the third through sixth sentences (24 U.S.C. 192, 199, and 200).

40 Stat. 373.

(l) The matter under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "MISCELLANEOUS OBJECTS." of an Act of July 7, 1884, chapter 332 of the laws of the first session of the 48th Congress, is amended by striking out the second sentence (24 U.S.C. 194).

23 Stat. 213.

(m) The matter under the heading "PANAMA CANAL." in the first section of an Act of June 12, 1917, chapter 27 of the laws of the first session of the 65th Congress, is amended by striking out the following (24 U.S.C. 196):

76A Stat. 699.

"Upon the application of the Governor of the Canal Zone, the Secretary of Health, Education, and Welfare may transfer to Saint Elizabeths Hospital, in the District of Columbia, for treatment, any American citizen subject to a hospitalization order issued under section 1637 of title 5 of the Canal Zone Code, whose legal residence in one of the States, territories, the Commonwealth of Puerto Rico or the District of Columbia for the purpose of eligibility for public medical care it has been impossible to establish. Upon the ascertainment of the legal residence of persons so transferred to Saint Elizabeths Hospital, the superintendent of that hospital shall thereupon transfer them to their respective places of residence, and the expenses attendant thereon shall be paid from the appropriation for the support of Saint Elizabeths Hospital.".

(n) An Act of July 18, 1940, chapter 638 of the laws of the third session of the 76th Congress (24 U.S.C. 196b), is repealed.

(o) The matter under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "MISCELLANEOUS OBJECTS." in the

first section of an Act of March 3, 1901, chapter 853 of the second session of the 56th Congress, is amended by striking out the second sentence (24 U.S.C. 197). 31 Stat. 1162.

(p) The first sentence in the matter under the subheading "MEDICAL AND HOSPITAL DEPARTMENT:" under the heading "MEDICAL DEPARTMENT." of an Act of May 11, 1908, chapter 163 of the laws of the first session of the 60th Congress, is amended by striking out the second proviso and the colon preceding and inserting in lieu thereof a period (24 U.S.C. 198). 35 Stat. 122.

(q) An Act of June 23, 1874, chapter 465 of the laws of the first session of the 43rd Congress (24 U.S.C. 212, 213, and 214), is repealed.

(r) The first sentence of section 4(a) of Public Law 86-571 (24 U.S.C. 324) is amended by striking out "Saint Elizabeths Hospital, at any other" and inserting in lieu thereof "any".

(s) Section 2104 of the Public Health Service Act (42 U.S.C. 300aa-3) is repealed.

(t)(1) The last sentence of section 206 of an Act of June 9, 1948, chapter 428 of the laws of the second session of the 80th Congress (D.C. Code 22-3508), is amended by striking out "Saint Elizabeths Hospital" and inserting in lieu thereof "an appropriate institution".

(2) Section 207 of that Act (D.C. Code 22-3509) is amended by striking out "the Superintendent of Saint Elizabeths Hospital" and inserting in lieu thereof "an appropriate supervisory official", and by striking out "the Superintendent of the hospital" and inserting in lieu thereof "that official".

(3) Section 208 of that Act (D.C. Code 22-3510) is amended by striking out "Saint Elizabeths Hospital" and inserting in lieu thereof "an institution".

(u) The first sentence under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "INTERIOR DEPARTMENT." of an Act of March 3, 1877, chapter 105 of the laws of the second session of the 44th Congress, is amended by striking out the semicolon and all that follows before the period (D.C. Code 32-401). 24 USC 202.

(v) The first sentence under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "MISCELLANEOUS OBJECTS." of an Act of March 3, 1879, chapter 182 of the laws of the third session of the 45th Congress, is amended by striking out the proviso and the colon preceding and inserting in lieu thereof a period (D.C. Code 32-402). 24 USC 203.

(w) The matter under the subheading "HOSPITAL FOR THE INSANE." under the heading "DISTRICT OF COLUMBIA." of an Act of March 4, 1913, chapter 149 of the laws of the third session of the 62nd Congress, is amended by striking out the second sentence (D.C. Code 32-404).

(x) Sections 4 and 5 of an Act of June 22, 1948, chapter 597 of the laws of the second session of the 80th Congress (D.C. Code 32-415 and 32-416) are repealed.

(y) The matter under the subheading "GOVERNMENT HOSPITAL FOR THE INSANE." under the heading "UNDER THE DEPARTMENT OF THE INTERIOR." in the first section of an Act of March 4, 1911, chapter 285 of the laws of the third session of the 61st Congress, is amended by striking out the second sentence. 36 Stat. 1421. 24 USC 165.

EFFECTIVE DATES

24 USC 225 note.

SEC. 11. (a) Except as provided in subsection (b), this Act shall take effect on October 1, 1985.

(b) Section 10 shall take effect on October 1, 1987.

Approved November 8, 1984.

LEGISLATIVE HISTORY—H.R. 6224:

HOUSE REPORTS: No. 98-1024 and Pt. 2 (Comm. on the District of Columbia).
CONGRESSIONAL RECORD, Vol. 130 (1984):
Oct. 2, considered and passed House.
Oct. 5, considered and passed Senate, amended.
Oct. 9, House concurred in Senate amendments.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 20, No. 45 (1984):
Nov. 9, Presidential statement.

O

Mr. FAUNTROY. On November 8, 1984, a historic event took place when President Ronald Reagan signed into law legislation to transfer St. Elizabeths Hospital from Federal control to that of the government of the District of Columbia. By doing so, the President ended an era of over 125 years during which the Federal Government administered and delivered institutional mental health care for the citizens of the District of Columbia.

As long as I can recall, past attempts to transfer St. Elizabeths Hospital were met with furor on both sides. Starting under President Truman and through each succeeding Presidency, legislation was drafted by the House and the Senate, the White House, the District and the Department of Health and Human Services.

I am sure that committee archives would show that the desire to transfer St. Elizabeths Hospital predates this century. But it was not until the summer of 1984 that we could bring all the forces together, air opposing views, and negotiate a fair and equitable piece of legislation that embodies the best of many proposals.

I am certain that none of us here today will forget the tug of war that went on around the witness table as the leadership and staffs from this committee, the Department of Health and Human Services, the District of Columbia government, AFSCME, the American Psychiatric Association, the American Association for the Advancement of Psychology, and the mental health law project worked throughout the summer and fall to reach the legislative agreement that became Public Law 98-621.

Today we begin the congressional review process as mandated by section 5 of Public Law 98-621, and as outlined in the committee report numbered 98-1024.

Before we call our first witness, I note that our Republican ranking minority member is not here. Does he have a statement to be entered into the record?

It is now my privilege to welcome our first witness, Mr. Wilford Forbush, the Deputy Assistant Secretary for Health Operations and Director, the Office of Management, the Public Health Service. We're very happy to have you, Mr. Forbush, and you may proceed as you see fit. Your entire statement will be entered into the record in its entirety.

**TESTIMONY OF WILFORD J. FORBUSH, DEPUTY ASSISTANT SECRETARY FOR HEALTH OPERATIONS AND DIRECTOR, OFFICE OF MANAGEMENT, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. FORBUSH. Thank you very much, Mr. Chairman. I would like to introduce those who are accompanying me today. I am a manager. I'm not a health professional, and I'm pleased to have with me Dr. William Prescott, the superintendent of St. Elizabeths Hospital and a well known professional in this field. On questions of clinical judgment and of that sort, I would like to turn to him to answer those.

I also have Jim Pittman, a familiar person to this committee, who is the Associate Director of NIMH in charge of the transition.

In the interest of time, I'd like to summarize the statement which you have put into the record at this point, and say that the

National Institute of Mental Health has reviewed the systems plan proposed by the District of Columbia and finds that it does represent appropriate mental health concept and is really consistent with the current state of the art in mental health care. We're pleased to endorse it from that standpoint.

I'm also pleased to say that we have been working very closely with the officials of the District of Columbia to start those implementation steps so critical to achieving the goal of this plan. I think we have taken appropriate interim actions, and we are prepared to do more as we reach the day of transition on October 1, 1987.

To me, the key thing really is the implementation. I think we have a good concept here, and we have to work as hard as we can on all sides to achieve the promise of this new plan.

I'd be pleased to handle your questions as best I can.

[The prepared statement of Mr. Forbush follows:]

STATEMENT OF

WILFORD J. FORBUSH

DEPUTY ASSISTANT SECRETARY FOR HEALTH OPERATIONS

AND

DIRECTOR, OFFICE OF MANAGEMENT

PUBLIC HEALTH SERVICE

BEFORE THE

COMMITTEE ON THE DISTRICT OF COLUMBIA

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

U.S. HOUSE OF REPRESENTATIVES

MAY 22, 1986

Thank you for the opportunity to testify today concerning the District's Preliminary System Implementation Plan to implement P.L. 98-621, "The Saint Elizabeths Hospital and District of Columbia Mental Health Services Act." I am Wilford J. Forbush, Deputy Assistant Secretary for Health Operations, and Director, Office of Management, Public Health Service. With me today are Dr. William G. Prescott, Superintendent, Saint Elizabeths Hospital, and Mr. James E. Pittman, Associate Director for Saint Elizabeths Hospital Transition, National Institute of Mental Health.

On October 1, 1987, the District of Columbia will assume full responsibility for mental health services to its residents including operation of Saint Elizabeths Hospital.

Today St. Elizabeths Hospital, which has played such a historic role in American psychiatry, provides care to approximately 1,600 inpatients (90 percent of these are D.C. residents). In addition, the hospital cares for approximately 2,500 outpatients, virtually all of whom are District of Columbia residents.

In keeping with the specifics and intent of the legislation, departmental personnel, particularly St. Elizabeths Hospital staff, have been involved in the development of the District's Preliminary Systems Implementation Plan under review here today. The plan has also been thoroughly reviewed by the Director, National Institute of Mental Health, and staff of the Institute who have expertise in specific areas of mental health care. They have evaluated the plan

as consistent with the state of the art from a mental health systems research, and practice perspective. The preliminary plan not only has been developed to meet its particular and unique needs but adheres to recognized standards and principles. The plan was developed to assure the continuation of the range of services necessary in an integrated and comprehensive mental health delivery system embodying: (a) community-based continuity of care and support services; and (b) an integrated array of psychiatric, medical, social, rehabilitation, vocational, and other support services.

It is a well-accepted mental health doctrine that continuity of care is necessary for persons in need of mental health services to receive the optimal and least intrusive care suited to their particular needs. Thus, the plan offers a range of outpatient, partial hospitalization, half-way house, aftercare, and related services to markedly decrease the number of persons who might otherwise be inappropriately placed in inpatient settings. The plan further provides for special programs and attention to the needs of the homeless mentally ill and increases services for children, forensic psychiatric services, as well as linkages and/or stabilizing services for alcoholics and drug abusers.

Throughout this planning and transition process, there has been extensive coordination, collaboration, and consultation with District, departmental, and SEH officials under the direction of the District's Mental Health System Reorganization Office. Numerous work groups composed of SEH and District officials have been established to work

on various aspects of the plan and its implementation. A considerable effort has also been devoted to planning for provisions that affect employees of the hospital, including regular meetings of the statutorily mandated labor-management advisory committee. In addition, a first draft of the proposed staffing for the new system has been widely circulated among St. Elizabeths employees. Revisions based on their comments are currently being undertaken by the Mental Health Systems Reorganization Office.

The Department of Health and Human Services has undertaken several important parallel endeavors to assure timely implementation of the Act. Among those completed are: audits of the physical plant and financial status of the hospital, and transfer of the J.B. Johnson Building and grounds to the District of Columbia government. We are now proceeding with or developing plans for undertaking completion of the transition during the remaining months, including:

- reorganizing and combining adult outpatient services to ensure a smooth and orderly transition of patient care into the new mental health system;
- combining and reorganizing emergency psychiatric services and developing services for the homeless;
- realigning hospital facilities into an acute care hospital and programs for longer term, intensive treatment and community living while retaining specialized programs for children, hearing impaired, and psychiatric nursing care;
- consolidating hospital and D.C. mental health patient data and developing a unified management information system;

- o beginning the review of training necessary for employees to assume positions in the new system; and
- o preparing an extensive information program targeted to affected employees which is focused on rights and benefits.

Overall, we believe the status of implementation is quite promising in achieving timely and effective administrative and program changes.Our goal is development of an integrated public mental health service system for District residents as intended by Public Law 98-621. The ground-work for a comprehensive community-based and community focused system has been made through this plan. The plan envisions a system that will afford opportunity to the mentally ill citizens of the District to regularly improve their access to improved care. Although we endorse the system plan prepared by the District, we recognize that achievement of its benefits depends on careful implementation throughout the transition process. I believe we have taken a constructive role to date and commit ourselves to carry through for the remainder of this important endeavor.

Mr. Chairman, we wish to do everything we possibly can to achieve this end, and we will be happy to answer any questions you may have.

Mr. FAUNTROY. All right. Thank you so much, Mr. Forbush.

On April 29 of this year, as you know, the subcommittee held oversight hearings on the events and circumstances surrounding the death of Mr. Emory Lee. As a part of the staff investigative report, St. Elizabeths Hospital was requested to provide the subcommittee with ways in which it was correcting the problems which may have contributed to the unfortunate event there.

My first question is: Is there progress being made to this end, and when can we expect a report on it?

Mr. FORBUSH. Yes. We are definitely making progress on that point, and Dr. Prescott is prepared to report on that now.

Dr. PRESCOTT. We have nearly completed our responses to the questions that were asked for us and the directions that were given to us through the staff report, and will be forwarding those this week to NIMH for their perusal and then on to your office. We expect that to occur within the next week.

Mr. FAUNTROY. Very good. We look forward to that. At this point we as a committee are concerned about the effect that the transfer process is having upon the professional and support staff out there at Saint Elizabeths and, therefore, on patient care.

Is patient care being adversely affected, in your view, at this point?

Dr. PRESCOTT. I don't think so, sir. We have at this point—we are experiencing some staff anxiety at the hospital, as would be anticipated under these circumstances. We've had some departures in key staff positions, but we've also had some new arrivals. We've had people who want to come into the new system, are anxious about the prospects of a modern state of the art, community based mental health system; and so far, we haven't experienced serious staff loss that would compromise patient care activities.

The morale problems, we're addressing directly and indirectly in a number of ways. My position is that patient care has not been adversely affected at this point, and we expect to maintain that throughout the transition position.

Mr. FAUNTROY. Those who left—Is it your view that they left because they were dissatisfied with the new arrangements?

Dr. PRESCOTT. Well, I wouldn't say that they left because they were dissatisfied with the new arrangements. There have been—of the professionals that have left, a number—very few, as a matter of fact of the professionals have expressed concern about the transfer of employment, but that's been very much a minority.

We've looked at the professionals who have left since the transition legislation was passed, and in most cases, virtually all cases, as a matter of fact, the reasons for their departure would have been reasons for their departure under any circumstances.

Mr. FAUNTROY. When we negotiated the fiscal package for Public Law 98–621, you may recall we tried to anticipate the deficit reduction mood of the White House and Congress, and we reduced the additional transfer supplemental from $210 to $135 million in hopes of foregoing additional future cuts.

My question is: In light of Gramm-Rudman, what has happened to the supplemental, and what is to be proposed in the future, if you know?

Mr. FORBUSH. Mr. Chairman, there are really two parts to that question. For fiscal year 1986, the one we're in now, the Gramm-Rudman across-the-board reduction of 4.3 percent on domestic programs has been applied to the Federal appropriations made to Saint Elizabeths Hospital, as required by law. That's just inevitable. It was also applied to a large portion of our outside income.

As far as fiscal year 1987, though, the amounts requested by the President are consistent with the New Systems Act, and there has been no reduction in that. However, if it comes to pass that later, when the whole situation is reviewed at the end of the summer, and if some further across-the-board reduction is required to meet the deficit target, the reduction would be made based on appropriations provided by Congress. That's a starting point for those reductions. It's the appropriations made.

Mr. FAUNTROY. You indicate, therefore, that you did take the 4.3-percent cut.

Mr. FORBUSH. Yes, sir. We had to.

Mr. FAUNTROY. What, roughly, did that cost you?

Mr. FORBUSH. Well, the—let me see. I don't have that overall dollar amount. It has been a difficult job for us to adjust ourselves to those—to that reduction. It came relatively late in the year. The total sequestration, as it's called in the Gramm-Rudman terminology, is $3.7 million, and that occurring as it did in the second quarter of the fiscal year has caused a great deal of difficulty for our management.

I think we have survived it. We are doing our very best to take that reduction with a minimum impact on our program, but certain things have had to be deferred and certain things of a discretionary nature, studies and this sort that we planned to undertake as part of the transition process, have had to be deferred until next fiscal year or cancelled altogether.

Mr. FAUNTROY. You anticipated my concern, and that is where the cuts affected the delivery of services. And $3.7 million?

Mr. FORBUSH. $3.7 million. Yes, sir.

Mr. FAUNTROY. That's a lot of money. What did you have to cut out, particularly with respect to patient care?

Mr. FORBUSH. Well, we do have an employment freeze in effect at the hospital. And that, of course—we're trying to minimize that impact on patient care, but it's difficult. It's difficult going.

We have deferred some equipment purchases, supply purchases, things like that that we can live without until next fiscal year. It's taking a bit of a risk, but I think we have to do it.

As I said, some discretionary items where we were going to do some studies or enhance information systems and things like this, we have had to defer.

Mr. FAUNTROY. What did you have to do with your salary level offerings for the professional staff?

Mr. FORBUSH. Well, that's dictated by the personnel classification system. We haven't changed that.

Mr. FAUNTROY. So you didn't touch that at all?

Mr. FORBUSH. No, sir.

Mr. FAUNTROY. On May 12 this year, channel 4, WRC, began a series of broadcasts concerning walkaway patients, as you may recall. Without getting into a long defense of the hospital, could

you enlighten us as to who makes decisions that allows patients to leave the confines of the John Howard Pavillion?

Mr. FORBUSH. Yes. Dr. Prescott is prepared to deal with those questions.

Dr. PRESCOTT. Yes, sir. Those decisions are made by a forensic review board which is a group that meets twice a week in the John Howard Pavillion to review all of these kinds of changes in patient status. The forensic review board consists of the division director, the medical director for the division, the chiefs of all of the disciplines which includes nursing, social work and psychology, and a representative from the St. Elizabeths Hospital Legal Office.

We have four classes of so-called ground privileges from the John Howard Pavillion, class A, B, C and D. Class A is one in which the patient is allowed to leave the John Howard building, but is secured; that is, handcuffed, and is accompanied by two escorts.

Class B is a category in which the patient is allowed to leave the building escorted, and class C is one in which the patient is allowed to leave the building but must report in by telephone contact on a regular basis throughout the period of time that they're out of the building. Class D is unsupervised ground privileges.

All of these categories are decided upon by the forensic review board and not the treatment teams of the patients, who we feel might be somewhat closer to the patient and, therefore, not as objective about these things.

So the way it works is that the treatment teams that work with the patients decide, on the basis of clinically relevant material, that the patient is ready for one of these categories of grounds privilege. They then apply to the forensic review board.

The forensic review board then goes over the material with the treatment team and the patient, and makes a decision to either concur or not to concur. Any change in status—the progression is always from the most intensive, restrictive grounds privilege to the least, and any change from A to D has to be decided on by the forensic review board as well.

So that's the process, sir.

Mr. FAUNTROY. How long has this process been in effect?

Dr. PRESCOTT. That's—it's been in effect for a long, long time, sir. It's been many years.

Mr. FAUNTROY. Are you under court mandate to let these patients out?

Dr. PRESCOTT. No, we're not, sir. The court is involved in our patients at John Howard in two ways. One is release from the hospital, release from mental health status, psychiatric treatment status into whatever other status they're going to go into, if it's release from the system or whether it's release to another secure facility. The court has to be brought in and has to concur.

Also, the court has to agree that any patient from the John Howard be allowed to have off-grounds privileges, and we have some patients from the John Howard who actually work off grounds, patients who have been there for many years usually, patients who have been treated very intensively and very carefully scrutinized, and often in fact have jobs. Then will come back to John Howard in the evening, for example.

Any situation involving that sort of treatment has to involve the court. So they're involved in those two ways, sir.

Mr. FAUNTROY. What relationship does the hospital have with the public defender's service?

Dr. PRESCOTT. We provide public defender's office with space at St. Elizabeths Hospital. They have access to our legal system. We're in constant communication with them. Any one of our patients, which includes forensic patients as well as civil patients, can use the public defenders on the grounds as their legal representative.

All they need to do is to contact somebody in that office, and they have representation. Once that initial contact is made, then the public defender's office has access to the records, to the treatment teams and to treating clinicians, and are treated as any other lawyer might be in the system, with the exception that we actually offer them office space and have established a long-time relationship, very positive relationship generally, with the public defender's service.

Mr. FAUNTROY. Let me finally return to the question of funding for fiscal year 1987. You said that the levels that are recommended by the President for fiscal year 1987, you feel, are adequate?

Mr. FORBUSH. Well, they were consistent with the legislation that mandates the transfer and the creation of a new system.

Mr. FAUNTROY. And if, therefore, the Supreme Court does not do what it ought to do and what we expect it to do and Gramm-Rudman is in effect, the next round of cuts would be—you'd have to take as well, is your understanding?

Mr. FORBUSH. Well, it's a two-stage process, Mr. Chairman. First, Congress has to sort of make programmatic judgments that we all hope will achieve the deficit target in that bill without sequestration. OK? The President's budget is one way to do that. The Budget Committee resolutions are alternative ways of doing that. If that goes through the regular legislative and appropriations process, no sequestration occurs.

However, if that process fails to do that, and if in the summer when the reexamination of the spending and the deficit and the income and all that is done, and it shows that the projected deficit is not at the target, then a new sequestration order has to be prepared.

If the Supreme Court puts down the procedure, then that would come up to a vote in Congress through the alternative process I specified in that act. But that sequestration thing only comes into effect if Congress—if the regular budget and legislative process fails to achieve the target.

So the budget request I'm referring to are consistent with achieving that target through programmatic means.

Mr. FAUNTROY. All right, gentlemen. Thank you so very much. We look forward to the report, as you promised, this week on the *Emory Lee* case, and I appreciate not only the thoroughness of your testimony but the candor with which you've responded to questions.

Mr. FORBUSH. Thank you, Mr. Chairman.

Mr. FAUNTROY. Thank you.

Mr. FAUNTROY. Let's move to our next witness, who is the director of the Department of Human Services for the government of the District of Columbia, Mr. David Rivers. I'm going to ask that Ms. Virginia Fleming will join Mr. Rivers. Ms. Fleming is director of the mental health systems reorganization office. We're very pleased to have both of you.

We have likewise your testimony. We will enter both in the record as prepared, and you may proceed in whatever manner you choose.

**TESTIMONY OF DAVID E. RIVERS, DIRECTOR, DEPARTMENT OF HUMAN SERVICES, GOVERNMENT OF THE DISTRICT OF COLUMBIA**

Mr. RIVERS. Thank you very much, Mr. Chairman. I'm David Rivers, the director of the D.C. Department of Human Services. With me is Virginia Fleming, the director of the D.C. Office of Mental Health Reorganization.

Mr. Chairman, you have before you a copy of my testimony, so I'd like to summarize my statement, if you will.

Mr. FAUNTROY. Certainly.

Mr. RIVERS. A major concern in my testimony is found on page 9. We are seriously concerned about the condition of the buildings that are being transferred to the new system in October 1987. We estimate that it will cost about $71 million to bring these buildings up to code and appropriate standards in order for us to resume a responsibility for the system.

As you are aware, the Federal Government has completed an audit. We had about $66 million that was appropriated sometime ago for the renovation of the buildings, but most of this money has been eroded given the inflationary costs in terms of renovation of the facilities.

So, again, our major concern right now in the system would be again trying to bring those facilities up to proper code in order for us to run our system. So, again, that would be a major concern that I'd like to amplify during my testimony.

Again, we have employed a very comprehensive process during this design of this plan. We had over 400 people and about 800 patients involved in the process. We think it's a very definitive and comprehensive plan, and one that we think that we can indeed manage within the District government.

Again, Ginny will get into the details of our overall plan. Thank you very much.

Mr. FAUNTROY. All right.

[The prepared statement of Mr. Rivers follows:]



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OVERSIGHT HEARINGS

ON THE DISTRICT'S PRELIMINARY PLAN TO IMPLEMENT PL 98-621

"SAINT ELIZABETHS HOSPITAL AND THE

DISTRICT OF COLUMBIA MENTAL HEALTH SERVICES ACT"

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ROOM 1310 LONGWORTH HOUSE OFFICE BUILDING

MAY 22, 1986 10:00 A.M.

I AM PLEASED TO HAVE THIS OPPORTUNITY TO TESTIFY BEFORE YOU TODAY, MR. CHAIRMAN, AS YOU UNDERTAKE YOUR REVIEW OF THE DISTRICT OF COLUMBIA'S PRELIMINARY PLAN TO IMPLEMENT P.L. 98-621, "SAINT ELIZABETHS HOSPITAL AND THE DISTRICT OF COLUMBIA MENTAL HEALTH SERVICES ACT". I AM DAVID E. RIVERS, DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES. WITH ME IS MRS. VIRGINIA FLEMING, DIRECTOR OF THE MENTAL HEALTH SYSTEM REORGANIZATION OFFICE IN MY DEPARTMENT.

PUBLIC LAW 98-621 ESTABLISHED THE PROCESS BY WHICH THE FEDERAL GOVERNMENT WILL END THE MANAGEMENT AND FUNDING OF ITS ONLY GENERAL PUBLIC MENTAL HOSPITAL, SAINT ELIZABETHS, AND THE DISTRICT WILL ESTABLISH A COMPREHENSIVE MENTAL HEALTH SYSTEM WITH FULL AUTHORITY FOR ALL PATIENT CARE. AS MAYOR BARRY STATED IN HIS LETTER TRANSMITTING THIS PLAN TO THE HOUSE DISTRICT COMMITTEE,

> "THIS NEW COMPREHENSIVE MENTAL HEALTH SYSTEM WILL HAVE A FAR-REACHING IMPACT ON THE QUALITY OF LIFE IN OUR COMMUNITY. WE WELCOME THE CHALLENGE OF ASSUMING COMPLETE HOME RULE RESPONSIBILITY FOR MENTAL HEALTH CARE AND THE OPPORTUNITY TO DEMONSTRATE THE EFFECTIVENESS OF COMMUNITY-BASED CARE. WE PLACE THE HIGHEST POSSIBLE PRIORITY ON A SUCCESSFUL ACCOMPLISHMENT OF THIS TRANSFER OF AUTHORITY AND ON PUTTING A COMPREHENSIVE AND INTEGRATED MENTAL HEALTH SYSTEM IN PLACE WHICH WILL SERVE THOSE MOST IN NEED."

ON OCTOBER 1, 1987, THE DISTRICT WILL ASSUME FULL RESPONSIBILITY FOR PATIENT CARE. TO CARRY OUT THAT RESPONSIBILITY WE WILL CREATE IN THE DEPARTMENT OF HUMAN SERVICES A NEW COMMISSION OF MENTAL HEALTH, PARALLEL TO THE COMMISSION OF PUBLIC HEALTH AND THE COMMISSION ON SOCIAL SERVICES. THIS NEW COMMISSION WILL MANAGE ALL PUBLIC INPATIENT AND OUTPATIENT CARE, INCLUDING BOTH CIVIL AND FORENSIC SERVICES. IT WILL INTEGRATE ALL THE SERVICES NOW PROVIDED BY SAINT ELIZABETHS HOSPITAL AND THE DISTRICT'S MENTAL HEALTH SERVICES ADMINISTRATION INTO A SINGLE, CENTRALIZED AND SIMPLIFIED MANAGEMENT STRUCTURE.

## PLANNING PROCESS AND TIMETABLE

WE HAVE TO DATE MET ALL THE REQUIREMENTS OF SECTIONS 4 AND 5 OF P.L. 98-621 WITH RESPECT TO PLANNING PROCESS AND REVIEW.

MAYOR BARRY TRANSMITTED THE PRELIMINARY SYSTEM IMPLEMENTATION PLAN TO THE DISTRICT COUNCIL ON JANUARY 1, 1986. MRS. POLLY SHACKLETON, CHAIR OF THE HUMAN SERVICES COMMITTEE, HELD TWO DAYS OF PUBLIC HEARINGS ON THE PLAN, WHICH WAS APPROVED BY COUNCIL RESOLUTION 6-566 ON FEBRUARY 28, 1986. ON MARCH 28, 1986, MAYOR BARRY COMMUNICATED TO CHAIRMAN CLARKE THE STEPS WE ARE TAKING TO RESPOND TO THE COUNCIL'S COMMENTS. BOTH OF THESE DOCUMENTS HAVE BEEN PROVIDED TO HOUSE AND SENATE OVERSIGHT COMMITTEES.

ON APRIL 1, 1986, MAYOR BARRY TRANSMITTED THE PRELIMINARY PLAN TO THE COMMITTEE ON THE DISTRICT OF COLUMBIA OF THE U.S. HOUSE OF REPRESENTATIVES AND THE COMMITTEE ON LABOR AND HUMAN RESOURCES AND THE COMMITTEE ON GOVERNMENTAL AFFAIRS OF THE U.S. SENATE FOR REVIEW AND COMMENT.

THE PLAN WHICH YOU HAVE BEFORE YOU, MR. CHAIRMAN, WAS CREATED IN FULL COMPLIANCE WITH SECTION 4(d) OF THE ACT, WHICH MANDATED THREE ASPECTS OF THE PROCESS:

1) WORKING GROUPS ESTABLISHED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES AND THE MAYOR BROUGHT TOGETHER SAINT ELIZABETHS AND DISTRICT OFFICIALS ALONG WITH PRIVATE PROVIDERS AND FAMILY AND CONSUMER REPRESENTATIVES. IN FACT, OVER 400 PERSONS WERE INVOLVED IN PLANNING AND OVER 800 PATIENTS IN THE SYSTEM WERE ALSO CONSULTED.

2) THE MAYOR AND THE SECRETARY ESTABLISHED A LABOR-MANAGEMENT ADVISORY COMMITTEE THAT INCLUDES THE EMPLOYEE ORGANIZATIONS AFFECTED BY THE ACT. IT HAS MET FREQUENTLY DURING THE PAST 16 MONTHS, HAS REVIEWED

DRAFTS OF ALL PARTS OF THE PLAN AND RELATED DOCUMENTS AND HAS MADE HELPFUL SUGGESTIONS. THEY WILL CONTINUE TO PARTICIPATE IN AND MONITOR THE IMPLEMENTATION OF THE PLAN, ESPECIALLY THOSE ASPECTS WHICH RELATE TO THE TRANSFER OF STAFF.

3) PUBLIC COMMENTS ON THE PLAN HAVE BEEN WIDELY SOLICITED THROUGH MEETINGS AND FORUMS AND HEARINGS HELD BY THE MENTAL HEALTH SYSTEM REORGANIZATION OFFICE, AS WELL AS THROUGH THE EXTENSIVE HEARINGS HELD BY THE DISTRICT COUNCIL UNDER THE CHAIRMANSHIP OF MRS. SHACKLETON.

THIS WIDESPREAD PARTICIPATION, MR. CHAIRMAN, ENSURED THAT THE PLAN TAKES ADVANTAGE OF A BROAD CROSS-SECTION OF PROFESSIONAL, CONSUMER AND ORGANIZATIONAL EXPERTISE IN THIS COMMUNITY. WE HAVE ALSO TAKEN A CLOSE LOOK AT SUCCESSFUL PROGRAMS AROUND THE COUNTRY AND WE HAVE INCORPORATED IN OUR PLANNING THE BEST AND MOST UP-TO-DATE IDEAS ABOUT COMMUNITY MENTAL HEALTH.

WE ARE ALSO TAKING ADVANTAGE OF THE SENSIBLE PROVISION OF THE ACT WHICH ALLOWS THE SHIFT OF SELECTED PROGRAM RESPONSIBILITIES AND STAFF RESOURCES FROM SAINT ELIZABETHS TO THE DISTRICT AND HAVE SO NOTIFIED THE CONGRESS.

FUNDING

MR. CHAIRMAN, THE OPERATING FUND PROVISIONS OF P.L. 98-621 HAVE BEEN HONORED BY THE DISTRICT GOVERNMENT. WE HAVE INCREASED THE MENTAL HEALTH SERVICES ADMINISTRATION BUDGET BY $11.2 MILLION IN FY 1986 AND BY ANOTHER $12.5 MILLION IN FY 1987. ALTHOUGH MUCH OF THIS PLANNED INCREASE MUST BE DIRECTED TO THE SUPPORT OF SAINT ELIZABETHS HOSPITAL THROUGH FY 1987, BECAUSE OF THE STAGED WITHDRAWAL OF FEDERAL APPROPRIATIONS, WE HAVE BEEN ABLE TO ACCOMPLISH SOME SIGNIFICANT INCREASES IN FUNDING FOR COMMUNITY-BASED CARE.

WE ARE, HOWEVER, DEEPLY CONCERNED ABOUT THE IMPACT OF GRAMM-RUDMAN-HOLLINGS CUTS ON THIS TRANSITION. IN SPITE OF THE FACT THAT THE DISTRICT AND FEDERAL GOVERNMENTS AGREED TO A PLANNED REDUCTION IN FEDERAL FUNDS OF OVER $6 MILLION FOR EACH YEAR OF THE TRANSITION, NEARLY $4 MILLION IN ADDITIONAL CUTS ARE NOW MANDATED FOR FY 1986. THIS HAS A SERIOUS NEGATIVE EFFECT ON OUR MUTUAL ABILITY TO CARRY OUT TRANSITION OBLIGATIONS. WE SEEK YOUR SUPPORT, MR. CHAIRMAN, FOR THE EXEMPTION OF SAINT ELIZABETHS FROM ANY FURTHER CUTS BEYOND THE PLANNED AND AGREED TO REDUCTIONS EACH YEAR OF TRANSITION.

BUILDINGS AND GROUNDS

IN ACCORD WITH SECTION 8 OF P.L. 98-621, WE HAVE IDENTIFIED IN THE PRELIMINARY PLAN THE PLANT TO BE TRANSFERRED TO THE DISTRICT TO PROVIDE MENTAL HEALTH SERVICES: ALL OF THE GROUNDS

AND FACILITIES EAST OF MARTIN LUTHER KING AVENUE AND SOME OF THE WEST SIDE INFRASTRUCTURE SYSTEMS THAT SUPPORT THE EAST SIDE. IT WILL ALSO BE NECESSARY FOR THE DISTRICT TO OCCUPY TEMPORARILY SOME OF THE WEST SIDE BUILDINGS WHILE RENOVATIONS ARE UNDER WAY AND THE INITIAL PLAN IS BEING IMPLEMENTED.

THE MAYOR HAS ESTABLISHED A TASK FORCE TO CONSIDER ALTERNATIVE USES FOR THE EAST SIDE. A MASTER PLAN PROPOSAL WILL BE FORTHCOMING UNDER THE TERMS OF THE ACT.

WE ARE DEEPLY CONCERNED, HOWEVER, ABOUT THE DETERIORATED CONDITION OF THE BUILDINGS AND INFRASTRUCTURE OF THE HOSPITAL AT THE TIME OF TRANSFER. THE FEDERAL GOVERNMENT HAS NOW COMPLETED A FACILITY AUDIT WHICH IDENTIFIES MINIMUM COSTS FOR RENOVATIONS TO MEET THE MANDATED CODE COMPLIANCE STANDARDS FOR BUILDINGS TO BECOME PART OF THE MENTAL HEALTH SYSTEM. WE BELIEVE THE AMOUNT NECESSARY FOR AN APPROPRIATE RENOVATION OF

THESE BUILDINGS IS ABOUT $71 MILLION. THE MAJOR EAST SIDE PATIENT CARE BUILDINGS ARE PART OF THE 1976 FEDERAL COMMITMENT OF BRING 1700 BEDS UP TO ACCREDITATION STANDARDS AND TWENTY YEAR LIFE EXPECTANCY. THE TASK IS NOT COMPLETE, LARGELY BECAUSE INFLATION GREATLY ERODED THE BUYING POWER OF THE ORIGINAL $66 MILLION APPROPRIATION. ALL OF THE PATIENT CARE BUILDINGS TO BE TRANSFERRED TO THE DISTRICT SHOULD MEET THE ORIGINAL STANDARD. FURTHERMORE, THE LAW REQUIRES THE DISTRICT TO MEET THE NATIONAL ENVIRONMENTAL STANDARDS FOR ACCREDITATION. IT IS UNREASONABLE AND UNECONOMICAL TO REPAIR AND RENOVATE BUILDINGS FOR MINIMAL CODE COMPLIANCE, WITHOUT RECOGNIZING THAT THEY WILL REQUIRE IMMEDIATE MAJOR RENOVATION TO MEET BROADER ACCREDITATION, LIFE EXPECTANCY AND EFFICIENCY STANDARDS.

MR. CHAIRMAN, THE DISTRICT AND FEDERAL GOVERNMENTS ARE NOW ENGAGED IN MORE DETAILED EXPLORATION OF THE DIFFERENCES AMONG VARIOUS ESTIMATES OF RENOVATION COSTS. WHEN THE EXACT DIFFERENCES ARE ESTABLISHED, WE WILL BE PLEASED TO PRESENT A MORE DETAILED REPORT TO THIS COMMITTEE, ALONG WITH OUR REQUEST FOR FULL SUPPORT OF APPROPRIATE RENOVATION OF THE FACILITY PRIOR TO TRANSFER.

TRAINING SUPPORT

P.L. 98-621 STATES THAT IT IS THE INTENT OF CONGRESS THAT THE FEDERAL GOVERNMENT CONTINUE HIGH QUALITY MENTAL HEALTH RESEARCH, TRAINING AND DEMONSTRATION PROGRAMS AT SAINT ELIZABETHS HOSPITAL. ALTHOUGH WE HAVE BEEN ADVISED BY NIMH THAT THE RESEARCH FACILITY WILL CONTINUE ITS ACTIVITIES, WE

HAVE NOT YET HAD ANY COMMITMENT TO CONTINUATION OF THE TRAINING PROGRAMS. THESE PROGRAMS ARE CRITICAL IN TWO IMPORTANT WAYS: (1) THEY ARE ESSENTIAL TO THE RECRUITMENT AND RETENTION OF HIGH QUALITY PERSONNEL IN THE NEW DISTRICT SYSTEM, AND (2) THEY HAVE A DEMONSTRATED NATIONAL TRACK RECORD THAT IS UNIQUE IN TRAINING PUBLIC PSYCHIATRISTS AND OTHER MENTAL HEALTH PROFESSIONALS. WE RESPECTFULLY URGE THE COMMITTEE TO MANDATE CONTINUED FEDERAL SUPPORT OF TRAINING ACTIVITIES AT THE PRESENT LEVEL THROUGH THE TRANSITION PERIOD.

PROGRAM COMPLIANCE

MRS. FLEMING WILL ADDRESS THOSE ASPECTS OF THE DISTRICT'S PLAN WHICH COMPLY WITH PROGRAM MANDATES OF PUBLIC LAW 98-621.

Mr. FAUNTROY. Ms. Fleming.

**TESTIMONY OF VIRGINIA C. FLEMING, DIRECTOR, MENTAL HEALTH SYSTEMS REORGANIZATION OFFICE, DEPARTMENT OF HUMAN SERVICES, GOVERNMENT OF THE DISTRICT OF COLUMBIA**

Ms. FLEMING. Mr. Chairman, I'm glad to have the opportunity this morning to highlight some of the features that respond to the particular questions that the committee has sent to us, and they go to four or five ways in which the plan does respond to the mandates of Public Law 98-621.

First, just one note that is not in the testimony, but the timetable of the—that is mandated in Public Law 98-621 is fully met to date. We have submitted the plan to all the review processes on time and had the public hearings required, and all of the process and timetable aspects of the plan are in full compliance with Public Law 98-621.

Now among the program mandates, the first and most important is, of course, the compliance with the Dixon decree. I have noted in the testimony that you will receive later this morning a certain understandable impatience on the part of the Dixon committee about the pace at which the new plan is getting put into effect and the changes that will come about under the plan.

I just want to remind you that, until October 1, 1987, the District will not be in charge of the comprehensive mental health services and we, therefore, designed a plan which accepts on that first day of that first year of total District management some things which will not be completely fixed or finished or comprehensive on that day.

The Congress quite properly suggested that there should be a plan—a comprehensive system in place by 1991, and gave us this period of 4 years after 1987, in which we would be increasing the outreach.

So I just want to point out that the system design that we're talking about and that is in the published plan is for the first year of comprehensive operations, and there's a great deal of emphasis in it on some of the very important and difficult transfer problems, our interest and attention to smooth transition for patients already in the system, before we reach out to add on to the number of patients in the system.

For example, we believe it is terribly important that patient care not be disrupted anymore than it has to be at this very critical point, and that we will, therefore, pay a great deal of attention to the patient and staff transfer in the first few months before we begin trying to increase the number of people enrolled in the system.

Now the way in which the plan will address the Dixon class, we think, is a very exciting comprehensive new system. It's a unified—it will be a unified adult services administration that will combine both inpatient and outpatient services.

Many of the problems that now plague the system have to do with the fact that it is still a divided system, and the connections

and continuity between inpatient and outpatient care will be resolved in the new model.

The plan focuses its priority on the most seriously disabled people through the newly designed community support system. Over 90 percent of the expenditures on adult patients will be on Dixon class patients. That is a dramatic increase in priority to the Dixon class over what now exists in the system.

By reconfiguring current St. Elizabeths programs into this—the new and more appropriate care which is, after all, the mandate of the Dixon decision that patients be served in the least restrictive and most appropriate setting, we will make a dramatic change in that first year, increasing the number of patients served in appropriate, as opposed to inappropriate, levels of care.

This will in turn release some funds which will be redirected, in addition to the new funds which we are increasingly spending on community-based care each year. So that the—in the more intensively staffed day hospitals, crisis beds and emergency case aides for those in an acute phase of illness, and psychotherapy, day treatment and rehabilitation programs linked to supervised and supported housing, vocational training and recreational programs for those in growth and training.

The continuity of care will be ensured by the presence of 40 new case managers, another dramatic change in services for Dixon class patients modeled on successful programs around the country and on, to some extent, to service management contracts that we have installed over the last 2 years in the District that have an extremely good track record. For example, the prevailing return to hospital rate for all patients is about something over 50 percent now. In our new service management contract, that ratio is down to 3 percent, a very significant increase in successful community-based training that has taken place over the last couple of years and is the model upon which we are proceeding, to a large extent, in the outpatient services for the Dixon class patients.

The preliminary plan also projects a total of 700 new supervised or supported residential facilities for these patients over the 6-year period. That is a doubling of the present number, again a very dramatic increase in the number of supported residential opportunities that will make possible these alternatives to institutionalization.

We have a very exciting new commitment from our housing department, so that the supply of congregate housing for the mentally disabled should be increasing significantly in each of the next 6 years.

Another essential new ingredient is the expansion of vocational training opportunities. We have again made a new agreement with our vocational training, our rehabilitation services administration, for a new supported employment program for the Dixon class patients, which is a model that has proven very successful in a couple of other cities and which we are adopting and incorporating into our plan.

The second important mandate in Public Law 98-621 is the provision of direct services for the homeless mentally ill. We all understand that, even with a more active case management system and a greater array of services and more continuity of care, there are

still some individuals who are reluctant to accept professional care or participate in organized day treatment or therapy programs, and who won't get the help that they need unless there's a very active, aggressive outreach program for them.

We believe that taking on this responsibility is very important. We have doubled this year and will double again next year and plan to double again in 1988 in the 1988 planning budget, which, of course, hasn't been through the city council yet. But our planning budget for the new mental health services has staged increases in direct, aggressive outreach services to the clinics, to the shelters, on the streets; and they are in part modeled on the community outreach branches which we have already begun to do on the model so successfully demonstrated by Dr. Stein in Madison, WI, and in part by some other contract programs that deliver direct services in the clinics and in mobile vans on the street.

We have not estimated in the first year of the plan—it is quite true. We have not estimated enough services for what we judge to be the very homeless mentally ill person in the city. We believe, in the first place, that it takes a considerable amount of time to develop the staff capacity to do this rather difficult, nontraditional service. We plan to increase it, as I say, to double that capacity each year, which we think is a manageable set of targets.

We also believe that, in the first year, fiscal year 1988, that we have to give, as we say, a great deal of attention to the patients already enrolled in the system. So that by reaching out to new patients, we don't neglect those patients that are already getting care.

We have also, we believe, very successfully met the obligations in the act to the employees of the hospital. The personnel working groups are working very hard to put in place all of the ingredients of that staff transfer. The patients rights provisions in the bill—We have designed a very extensive and elaborate internal and external advocacy program. We think that will be a very strong model in that respect.

We have a design for a new quality assurance system based on the new management information system, which is also well underway; a systemwide new management information system that makes possible the kind of data and information that in turn makes quality assurance possible, because you have accurate data against which to measure the outcomes of care.

On the final mandate of the bill that I want to highlight this morning has to do with cost effectiveness to the city. Mr. Rivers is also—of the system. Mr. Rivers has mentioned our grave concern with the condition of the buildings which has a cost effectiveness impact.

We are also deeply concerned about the condition of the powerplant. You have, Mr. Chairman, received a letter detailing that which we would like to ask be made part of the record, and our recommendations on that point.

It's terribly important that we don't waste on the buildings, that are so expensive to maintain, the money that we should be spending on patient care. So that is why we want to emphasize these pieces of unfinished business about capital construction.

Thank you, Mr. Chairman.

[The prepared statement and attachments of Ms. Fleming follow:]

STATEMENT OF

VIRGINIA C. FLEMING

DIRECTOR, MENTAL HEALTH SYSTEM REORGANIZATION OFFICE
DEPARTMENT OF HUMAN SERVICES

before the

COMMITTEE ON THE DISTRICT OF COLUMBIA

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

U. S. HOUSE OF REPRESENTATIVES

May 22, 1986

I appreciate this opportunity to describe for the Committee several aspects of the Preliminary System Implementation Plan which ensure that programs in the comprehensive mental health system will comply fully with the mandates of P. L. 98-621.

1. Among the most important mandates is that the comprehensive system comply with the court consent decree in Dixon v. Bowen. The Preliminary Plan assures this compliance in several ways.

First, a unified Adult Services Administration will be fully accountable for both inpatient and outpatient services, closing the gap between hospital and aftercare programs. That Administration will move beyond the comprehensive center model of the last 20 years to focus its priority on the most seriously disabled patients through the newly designed Community Support System. Over 90 percent of expenditures on adult patients will be concentrated on persons in the Dixon class at most serious risk of hospitalization.

By reconfiguring current Saint Elizabeths Hospital programs into the appropriate hospital, nursing and residential levels of care, funds and staff will be available for reallocation to a new continuum of community based programs: (a) more intensively staffed day hospitals, crisis beds and emergency case aides for those in an acute phase of illness, and (b) psychotherapy, day treatment and rehabilitation programs linked to supervised and supported housing, vocational training

and recreational programs for those ready for growth and training. Continuity of care will be ensured by the presence of 40 new case managers in the community centers and by expansion of the present service management contracts which have maintained long-institutionalized patients in the community over the past two years with extraordinary success. A single point of entry into the system, individual treatment plans and frequent case consultations will prevent the fragmentation and lack of continuity that now keep care from being fully effective.

The Preliminary Plan projects a total of 700 new supervised or supported residential facilities for these patients over the six year period, made possible by an array of new housing initiatives including expansion of the state SSI supplement, technical assistance for special housing development and programs to encourage apartment living arrangements in addition to group homes. Treatment in the least restrictive setting is made possible by this development of alternatives to institutional care. An equally important new ingredient is expansion of vocational training and supported employment opportunities for disabled patients, to enable them to lead more independent lives in the community.

2. A second important mandate is the provision of direct services for the homeless mentally ill.

Even with active case management, some individuals who are reluctant to accept professional care or to participate in organized day treatment or therapy programs will not receive the help they need unless the mental health system reaches out with active service delivery to such persons in shelters or on the streets. The new comprehensive mental health system will use a combination of approaches to such persons:

(a) Community Outreach Teams designed on the Madison, Wisconsin model will continue to be based in one or more community centers to maintain contact with homeless patients wherever they may be until they are ready for more traditional services;

(b) contract services will expand to provide additional psychiatric care in shelters and to fund community agencies to provide services and housing assistance to homeless persons who are mentally ill;

(c) one or more mental health professionals will join the mobile van to be sponsored by the Commission on Public Health to reach out to those who live outside of shelters;

(d) a greatly expanded emergency services mobile outreach staff will be available because of the merger of the two existing emergency services into one centralized unit, that will be on call to respond to homeless persons in need of acute care, providing intensive medical care and crisis stabilization beds or hospitalization when necessary, and

(d) these services will be evaluated and strengthened by a coordinator for mental health care to homeless people at the highest level of the Commission.

3. The Plan also ensures that the transition to a comprehensive District system is being carried out with maximum consideration for the interests of employees of the Hospital, and provides a right-of-first-refusal to such employees for employment at

comparable levels in positions created under the Plan. We have determined that in order to staff the new comprehensive service system, we will require about 2,000 new employees in the Department of Human Services and about 400 new employees in other support services, as well as new services purchased through contracts with District agencies and hospitals. During the summer of 1987, all of the new positions will be offered first to current Saint Elizabeths employees. We are also working with the federal government to carry out the provisions of the law which ensure that any remaining employees are absorbed into vacancies in related service systems. A working group of federal and District officials is working carefully to ensure that all the provisions of Sections 6 and 7 of the Act are fully met.

4. Patient rights in the new system will be protected by an extensive internal advocacy system and by expansion of the present contract with the District's protection and advocacy agency. In addition, the rights of patients in the Dixon class will continue to be represented and protected under the court decree.

5. The development of a new quality assurance system, strengthened by a comprehensive Management Information System now being developed, will enable the new system to monitor and enforce policy, performance and outcome goals. All facilities

in the new system are expected to be licensed and certified for reimbursement by the time of the transfer and the District will apply for appropriate accreditation surveys to be staged over the transition period.

6. Finally, the cost-effectiveness of the new system will be enhanced by the integration of services to eliminate duplication and by the shift of resources to community-based care to prevent unnecessary institutionalization.

Another important step toward cost effective care is the consolidation of administrative and institutional services of the new Commission on Mental Health in 20 major buildings on 115 acres of the Saint Elizabeths site east of Martin Luther King Jr. Avenue. This complex includes all the patient care buildings targeted in the Congressionally approved capital project under way since 1976. It includes the 10 patient care buildings which will have been renovated by the time of transfer as well as 4 other major patient care buildings and a number of day care and support facilities which still require major renovation.

A serious issue of cost-effectiveness as well as safety is also presented by the condition of the power plant at Saint Elizabeths. This problem is fully outlined in Mr. Rivers'

recent letter to you, Mr. Chairman, and a copy is attached to this testimony. The replacement of this plant at the earliest opportunity is essential.

In summary, the District's Preliminary Plan completely restructures services to mentally ill residents of the District and creates a fully integrated, comprehensive system. We do not underestimate the amount of work which lies ahead to assure a smooth transition for patients and staff, but the Plan provides a clear blueprint which acknowledges the difficulties and provides practical steps to overcome them. We are heartened by the widespread support which the plan has already received and by the number of persons already deeply engaged in its implementation. We will be pleased to answer any questions which you may have.

APR 10 1986

801 North Capitol Street, N.E.
Suite 700

The Honorable Walter E. Fauntroy
U.S. House of Representatives
2135 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Fauntroy:

I write this letter to outline for you the untenable situation with respect to the Saint Elizabeths Hospital (SEH) power plant and related energy issues which require corrective action in advance of the transfer of the hospital to the District Government.

Mayor Barry forwarded to the appropriate congressional committees a full outline of the capital budget issues at the hospital as part of the transmittal of the entire Preliminary Mental Health Plan on April 1, 1985. In view of your specific interest in the power plant and temperature control issues, we are providing at your request, the following additional analysis and recommendations.

In recent months, we have seen dramatic examples of serious problems involving the power plant and temperature controls. First, a series of boiler breakdowns culminated in a six-hour loss of service on Christmas Day. Additional breakdowns have occurred twice since Christmas, including the blow-out of one of the turbines within the last few weeks. Second, the lack of temperature controls in both patient care and administrative buildings causes unhealthy and wasteful conditions throughout the hospital. The federal government should correct these problems before the transfer of responsibility for these facilities.

Because many areas of the hospital are overheated, staff routinely turn on air conditioners and open windows in mid-winter. This appallingly wasteful practice is made necessary by the lack of adequate temperature controls in hospital buildings.

Since July of last year we have attempted to correct this problem by working out a contractual agreement with the U.S. Department of Health and Human Services (DHHS) that would allow replacement of existing temperature controls on all relevant SEH buildings with state-of-the-art controls. The installation of such equipment would significantly reduce fuel consumption and dramatically improve the comfort of both patients and employees. Further, the contract for the installation and monitoring of this equipment would require no start-up costs or capital outlays by either the federal or District government. The contractor would be paid a percentage of the difference between fuel costs prior to and after installation.

We feel a project of this type could and should be implemented before next fall. Because SEH is still a federal property, the contract cannot be executed without federal consent and participation. Thus far we have not been able to reach agreement with DHHS on a specific approach which would satisfy legal advisors. Our fear is that further delays will result in another winter at SEH with unnecessarily high fuel bills and excessive room temperatures.

Regarding the SEH power plant, we have been advised that the boilers are five years behind the recommended replacement schedule. The recently completed federal audit indicates that an extraordinary amount of mechanical and electrical work would be necessary to bring the power plant up to code compliance. The audit estimates that this work will cost about $3 million and includes replacing three boilers which are estimated to be beyond their usefulness.

The power plant consists of five boilers installed between 1964 and 1971. Two of the oldest boilers are out of service and are being retubed. The third is out of service and beyond repair. The recent breakdowns are attributed to the two newer boilers which are scheduled to be reconditioned this summer. Even after reconditioning the boilers, there will still be a high risk of shut-downs. The history of the power plant indicated that the expected life span of the existing boilers may fall far short of average life expectancy due to the high demand which is placed on them. In addition, labor and maintenance costs will remain high because of the age of the boilers. Currently, it takes the equivalent of 30 full-time employees to operate the power plant at a cost of $859,000 per year.

In spite of this information, no replacement funds have been allocated for new boilers. In fact, current plans are to spend as much as $375,000 between now and the time of the

transfer to retube and otherwise refurbish boilers which are past their prime. We believe that current federal strategy is not cost-effective and will only result in pushing major power plant problems forward into the period of District ownership.

Our strategy, which is backed by an independent engineering study, agrees with the facility audit recommendation of replacing the boilers and goes further by calling for the construction of a new power plant at a cost of $3.6 million with a pay back period of 1.5 years. The relatively short pay back period is the result of considerable fuel savings resulting from efficient boilers and modern temperature controls. Additionally, because a new power plant will require less maintenance, we estimate power plant personnel costs will be reduced by about $320,000 per year.

A new plant will provide boiler efficiencies in the range of 85 to 90 percent as compared to the present 70 to 75 percent. New, more efficient designs of fans, pumps, turbines and heat exchangers over the last 20 years will contribute to improvements in overall plant efficiency. Improvements in burner designs provide better combustion efficiency, resulting in lower operating costs, less air pollution and reduced damage to internal components.

We believe that plant replacement is a far more cost-effective solution, even though the cost of building a new plant will be slightly higher. The present patchwork system of maintenance is draining funds away from capital intended to renovate patient care buildings. Further, the current federal repair strategy appears to be in conflict with the federally-sponsored audit which recommends boiler replacement. Any strategy that advocates continuing to fix and use boilers that are beyond their usefulness is costly and represents a continued risk to patient safety and comfort.

Based on our analysis of the power plant and temperature controls at SEH, I request special assistance from you to do the following:

1. Encourage the federal government to quickly resolve all issues which now impede the selection of a contractor to install new temperature controls on SEH buildings;

2. Urge the federal government to allocate approximately $300,000 for architectural and engineering designs for a new power plant (The capital authority for this allocation is already in place. Special instructions to procure this design on an emergency

basis and, if necessary, a non-competitive basis are needed in order to complete the design phase by September 1986; and

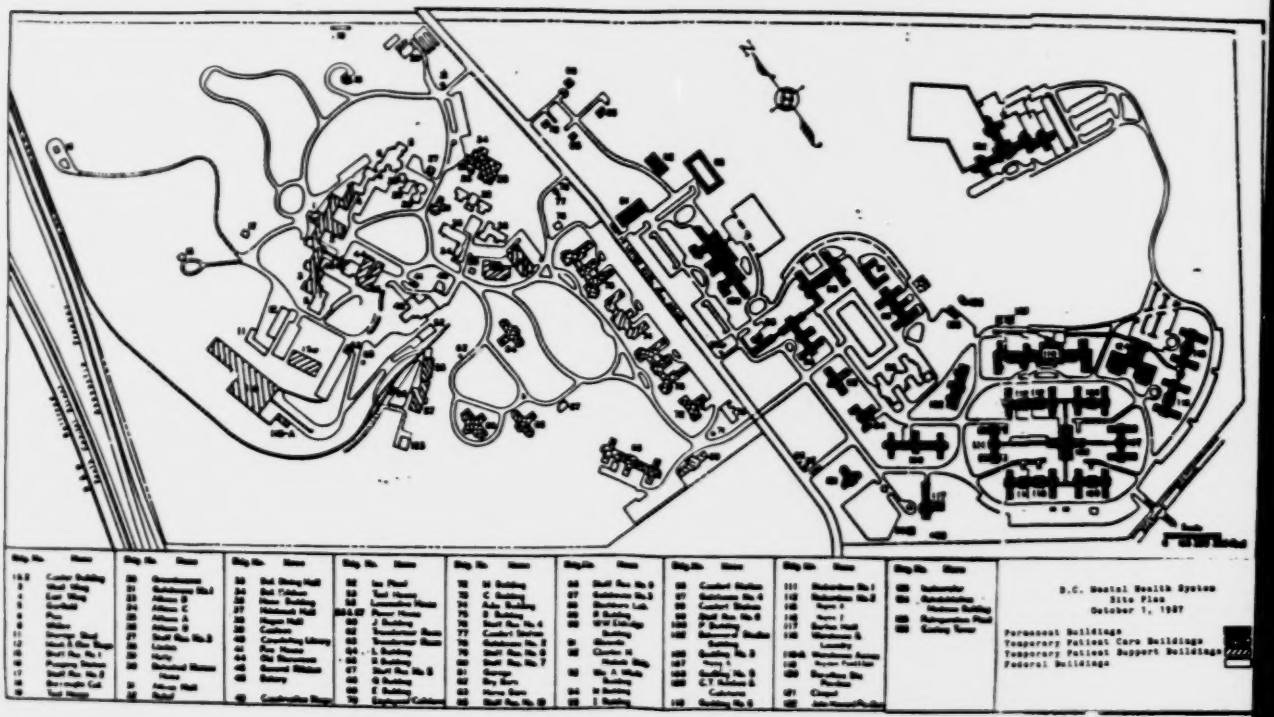
3. Work with House and Senate appropriations committees to ensure that the $3.6 million cost of the new power plant is placed in a bill appropriating these capital costs in FY 1987.

I believe these actions will result in a level of environmental safety at Saint Elizabeths Hospital consistent with the federal obligation to its institution at the time of transfer. I welcome your interest and concern on this important subject. Please let me know if I can provide further information.

Sincerely,

David E. Rivera
Director

cc: The Honorable Ronald V. Dellums
Ron Willis
John Gnorski
Dwight E. Cropp
Thomas Downs
William Prescott
Wilford Forbush


D.C. Dental Health System
Site Plan
October 1, 1987
Permanent Buildings
Temporary Patient Care Buildings
Temporary Patient Support Buildings
Federal Buildings

Mr. FAUNTROY. Ms. Fleming, I want to thank you. We've been aware of your hard work in this area over the years and your commitment and dedication to assuring that we do deliver quality mental health services to all the citizens of the District of Columbia. I just want you to know that I, for one, appreciate it. I appreciate your work.

Ms. FLEMING. Thank you, Mr. Chairman.

Mr. FAUNTROY. You've answered a number of the questions that I had in mind in connection with section 2 of Public Law 98-621, which has to do with a number of the details that we were concerned about.

You mentioned particularly the issue that has become a frontburner issue in recent months, that of the homeless. We held hearings here in this committee about a year ago to take testimony from experts on the problems of the homeless around the country, and one of the questions raised and answered was how effective are large facilities for housing and caring for the homeless.

We have seen the Second Street facility made available for renovation as a rather large facility, and I have been somewhat concerned about the extent to which we're going to be able to cover the mental health needs through government of the persons there.

I have two questions: One, what are we doing pursuant to the directive in section 2 that we develop a continuum of inpatient and outpatient mental health care for the scattered site idea?

Ms. FLEMING. Reaching out to the homeless, we think, requires a combination of approaches, Mr. Chairman. We have tried to put in place in the shelters clinical services, psychiatric services. We have now the capacity to visit out of our crisis branch and through volunteer psychiatrists and through some of the psychiatrict residents at St. Elizabeths. We are providing direct onsite services in almost all of the 12 publicly supported shelters in the city now. Now that is just a beginning.

We also believe that you have to go to where people are on the street, and the commission on public health is now organizing a van which will move out in connection with the food services that are also being offered by mobile vans, and will try to deliver to people on the street frontline health and mental health services. That is another new initiative the department is undertaking this year.

However, we put most of our emphasis on trying to return chronically mentally ill patients who are homeless to a more stable environment and a more stable treatment. We believe that most of our efforts should be directed toward what some people call mainstream care.

It is not always easy to do that with people who are resistant to treatment, but there are special skills, special staff skills that can be developed, and special kinds of housing that are more acceptable to homeless mentally ill people than others.

For example, we find that very few people we work with who are homeless want to live in group-home settings. They have much more of a commitment to independence, personal independence, and they prefer apartment settings.

We have two demonstration programs we hope to launch this fall that will do a very specialized kind of housing and treatment and

case-management projects to reach out, in one case, to homeless—in both cases, actually, to homeless mentally ill women who are particularly vulnerable group of that population.

So we are experimenting with small scale efforts tailored to the particular—It is not a homogeneous group, as you know, Mr. Chairman, and there are different things needed for different groups. That's what we're trying to do.

Mr. RIVERS. Mr. Chairman, this is also a major concern. Obviously, we try to do a lot of outpatient homelessness—of mentally retarded persons in the community, but there is also attached to that a community reaction. It's not easy to open up whether you do scattered site, whether it be a small facility, a large facility.

We are having some major opposition from community groups in terms of opening up shelters or other facilities to serve our client population. So it is a problem overall in terms of doing—of opening up any shelter.

Mr. FAUNTROY. Has the Federal Government honored its commitment fiscally over the last—during this period? What happened, for example, on the supplemental $135 million?

Ms. FLEMING. Well, there's a little bit complicated fiscal situation, Mr. Chairman, in that when the agreement that we all made in 1984 and the funding chart went forward, it was based on an expectation of pay rates at St. Elizabeths Hospital as in all Federal agencies which were at the time predicated on a 5-percent pay cut.

The Congress did not accept that Presidential proposal and put back the pay scale. So that at St. Elizabeths there has always been, since in 1986 and 1987, a shortfall of a couple of million dollars, which resulted from the fact that Federal agencies were all expected to absorb that shortfall.

That was a manageable deficit. When you put the Gramm-Rudman cuts on top of that, the additional $3.7 million that you've just been hearing about, it makes a shortfall against our projected 6-year agreements that becomes increasingly difficult to handle.

We agree with the superintendent's testimony that patient care has not been totally disrupted—that it is being managed at the hospital. But the things that are being deferred are, from our point of view, some very essential things about transition.

It is possible, for example, that if the Gramm-Rudman cuts continue into fiscal—or happen again in 1987, even though the President's budget honors the agreement, we don't know what's going to happen during 1987. Any additional cuts in 1987 would defer into fiscal year 1988 a great many expenditures, which would then become a full District responsibility, thus pushing forward into the District's budget things which should have been expended by the Federal Government in 1986 and 1987.

The management information system, for example, upon which so much of our mutual ability to demonstrate these changes and assure quality in the system, for example, has already been set back by these shortfalls. We feel very strongly that any further impact of Gramm-Rudman would be very difficult for us to handle.

Mr. FAUNTROY. Counsel has a related question on this.

Mr. WILLIS. If we could, on the scattered site that the chairman raised, Mr. Rivers pointed out that there's been a reaction from the community which is true not only here, but I understand across

the Nation. Are you planning educational seminars for the community itself so that folks understand who's coming in, who they are, and more importantly, who they're not, to ease this transition?

Mr. RIVERS. As part of our ongoing process, we provide the education and training for the community group, to brief them in terms of what kind of facility would be in there, and a detailed description of the population to be housed within the facility. That works sometimes, and sometimes it doesn't. People—they will support your programs in terms of your intent, but they would prefer that the community or shelter be located within another neighborhood other than their own.

So it is a problem, but we do and we will provide education in terms of who the population would be that will be moved into the community.

Mr. WILLIS. This would be through the ANC process?

Mr. RIVERS. Yes.

Ms. FLEMING. We also have an NIMH funded community support program grant, and this year MHSA has launched a particular broader effort, communitywide effort, using some people who are rather skillful at this and who have a great deal of the best national information to counteract some of the mythology. For example, the impact on property taxes just is not demonstrated in fact, although people continue to think that it does have such an impact.

So we're trying to pick out some of these broad factual issues to help educate people in the community about—that it really is a community responsibility and does not have a negative impact.

Mr. WILLIS. One more question, Mr. Chairman. Then I'll turn to you. You'll recall, Mr. Chairman, that we had quite a discussion in Anacostia in November about the number of sites that are being placed in particular wards. Our notion of a scattered plan is truly to scatter it throughout all of the wards within the District of Columbia and not have them concentrated in one area.

What are you doing, and how is the plan going to prevent the kind of concentration that in the past has occurred?

Ms. FLEMING. Well, we share the belief that smaller shelters are better than large concentrations, but we again just underline the belief that permanent or at best, second stage housing, is the real answer where you scatter people into apartments or clustered situations that are not shelters at all but are real homes. And they can be supervised and supported, and they can have strong elements of case management and mental health treatment in them, but they become the beginning of a real home rather than a shelter.

That is the ultimate desirable goal.

Mr. WILLIS. Now these would be scattered throughout the city?

Ms. FLEMING. Scattered—yes, yes; just as we propose to scatter all housing. Right.

Mr. WILLIS. Thank you, Mr. Chairman.

Mr. FAUNTROY. Thank you. Finally, I had asked HHS and St. Elizabeths Hospital to bring us up to date on the future programs for patients with a dual diagnosis, both mental retardation and psychiatric disorders. What is the city planning as a part of its new system to meet the needs of this population?

Ms. FLEMING. It's a very important question, Mr. Chairman. We last year identified in the course of looking at the patient popula-

tion at St. Elizabeths and elsewhere—identified a group of patients at the hospital, probably as many as 150 of them, who were either primarily mentally retarded or both mentally retarded and mentally ill.

We did not at the time of the publication of the preliminary plan have a very detailed proposal about that. We have had, however, over the last couple of months a task force working on that issue, and we've come forth with a set of things that need to happen.

What we have really is a system for the mentally retarded which has become quite developed and community based over the last 3 or 4 years, and a mental health system which is going in the same direction; but we have not yet developed the professional capacity. We don't have the staff that are trained in both skills as yet, and we don't have the continuum of care as yet, although the principles are exactly the same.

We do—the task force report will be available in about 6 weeks, and we do estimate that among the most serious needs will be a need for training of staff and, of course, the funding that's necessary to release staff to get that training. So those are both the training—the development of curriculum itself. We think probably over 3 years it may cost us as much as $500,000 in each of those years to develop that curriculum, to institutionalize it in one of our local universities or institutions, and to see to it that a sufficient number of staff in both systems has these skills, and that the continuum of care for that group is developed.

As I say, we'll be glad to share that report with you in about 6 or 8 weeks time.

Mr. FAUNTROY. I would appreciate your sending it to us as soon as it is completed.

Mr. Rivers and Ms. Fleming, I want to thank you so much for presenting us with an excellent overview regarding the mental health, the reorganization preliminary plan.

I know you are aware that section 8(b) of the law states that the Mayor shall prepare and submit to the committee on or before October 1, 1991, a master plan for use of all real property and so forth not transferred or excluded to subsection (a). I look forward to that legislative package and will schedule hearings at that time.

I want to assure all of the interested parties that, at the appropriate time, we will make a very—take a very close look at that, and will consider its effect on the overall delivery of mental health services.

Thank you so very much for your testimony.

Mr. FAUNTROY. We come now to a high point of our hearing today. We are pleased to have as our next witness the Honorable Polly Shackleton, council member from ward 3 of the District of Columbia.

Ms. Shackleton has served the citizens of the District of Columbia for many years, the last 11 of which have been as council person for ward 3. During that time she has been a champion of the disenfranchised and the mentally ill. Long before homelessness moved from the streets to the stage, Polly Shackleton was calling for changes in the way the Federal and local governments are meeting their needs.



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Many of the more popular social programs we have come to take for granted were new and innovative when Ms. Shackleton introduced them to members of the council. Her personal involvement in the difficult question surrounding St. Elizabeths Hospital and its proper place as a part of the District of Columbia governmental mental health program dates back to 1969, as I recall.

I recall, in our shaping of the very first Washington agenda, leaning very heavily on Ms. Shackleton for guidance and direction as to how we should be moving in this area. In 1970, she served as a member of distinction of the Rome Commission, a Presidentially appointed body established to give direction as to whether, when and how St. Elizabeths Hospital should be made a part of the District mental health system.

In 1980, she served on a task force created by the Department of Health and Human Services, then Secretary Patricia Harris and the Mayor of the District of Columbia. So her appearance before this committee and the District of Columbia probations on the St. Elizabeths Hospital question of areas which came before the District of Columbia Council certainly have enlightened and enriched the legislative process and all of us.

I know my colleagues on this committee, many of whom are very committed to a bill at this time on trade relations with which Ms. Shackleton is certainly not unfamiliar, join me in praising you for the kind of leadership you've given, the kind of unceasing work that you have given to this city and to, indeed, the Nation on this question. And as you retire, Polly, we wish you the very best and want you to know that we will miss your wisdom and your insights as we carry on the work of providing citizens of our great city the kind of first-rate services that they need and deserve, that you've already advocated. So I'm very happy to have you and look forward to your testimony.

**TESTIMONY OF HON. POLLY SHACKLETON, COUNCIL MEMBER, COUNCIL OF THE DISTRICT OF COLUMBIA**

Ms. SHACKLETON. Well, thank you very much, Mr. Chairman. I certainly appreciate your kind words. You and I have worked closely together, even before we were both on the appointed city council. I think, years before that, we fought freeways. We did all kinds of things together, and of course, you were the vice chairman of that appointed council which I served with you on. So we've been close, and I appreciate certainly your very kind words and your continuing concern in all our problems. I don't know what we'd do without you up here, frankly. So I just want to say——

Mr. FAUNTROY. Thank you so very much, Polly. You know, you just remind me, it has been 20 years since we went over to the White House. Wasn't that some day?

Ms. SHACKLETON. Yes; it's a long time ago, and we've both been working at it. Even though I am not running for reelection and will not be on the council after the end of this year, the end of my term, I want to assure you that I will continue my interest and concerns and will be working with you and others on many of the issues that I've been involved in over the years.

Mr. FAUNTROY. Thank you.

Ms. SHACKLETON. I will not read the first paragraph of my statement, because you said some more than I have here, actually. But I do want to say that I fully—as chairman of the council's committee on human services, I fully support the transfer of authority to the District government for a comprehensive mental health system and the creation of a commission on mental health within the D.C. Department of Human Services to carry out the new responsibility.

Many of the problems which have plagued the divided system over the years, I believe, can be resolved by unifying and integrating services in this way.

Our committee—my committee, which I chair, held 2 days of public hearings in January, giving a broad opportunity to professionals and interested individuals and organizations to comment on the plan. It is clear that there is widespread support for the proposed organization and structure of the commission on mental health and for the principles which guide its emphasis on two principal groups of clients, children and youth, and chronically mentally ill adults.

My committee also noted the widespread participation of many family members, professionals, and organizations in the development of the plan. This will ensure that our system is designed to meet the needs of our population and to achieve the goals set by the community for mental health services.

In the resolution which our committee proposed and was passed by the council on February 28, of this year, we noted several areas which needed further attention. I think you've already—you, and Ms. Fleming has responded, have already addressed the concern about the patients with the dual diagnosis of mental retardation and mental illness, and also about patients who are both mentally ill and substance abusing.

I'm advised that in both these areas the reorganization office, as Ms. Fleming stated, together is working on that. We also, in our resolution from the committee—we requested detailed cost and revenue data in the final plan, and are particularly interested in reviewing the financing of children's programs across the D.C. Department of Human Services and the public schools.

The council takes a keen interest in the development of plans for that part of the St. Elizabeths campus which will not be used directly by the mental health system. The Mayor has now established a task force to assist him in the development of guidelines and proposals, and we expect to review his recommendations in the fall.

Our deepest concern, of course, relates to the potential cuts under Gramm-Rudman, and you've already gone into that in detail. So I won't repeat it, but we are very, very disturbed about that.

I also—I would hope, and I'm sure you're going to do everything you can to prevent further harm in our effort by an instruction from Congress to the Federal Executive to exempt the Gramm-Rudman actions.

We also, which has been mentioned, urge your attention and support for the funding of the renovation of the St. Elizabeths facilities, which will be transferred to the District, and certainly the Federal Government must not pass along an unfinished commit-

ment to bringing these facilities up to appropriate treatment standards—standards that will meet the test of accreditation.

Your committee, Mr. Chairman, took the lead in mandating the Federal commitment to this renovation in 1976, and I know we can count on you to pursue the task until it is complete.

In closing, let me repeat that the District Council is monitoring the development of this comprehensive mental health system for our community with care and diligence. We are satisfied that the work is proceeding on the required timetable, and is in full compliance with the mandates of Public Law 98-621 and with all applicable District statutes.

We look forward to receiving the final plan from the Mayor in October of this year and to supporting the assumption of full responsibility next year.

Again, our most serious concerns are that the Federal Government is going to welch on its commitments, and we know that you will do everything possible to prevent that.

I thank you for having the opportunity to present our views this morning.

[The prepared statement of Ms. Shackleton follows:]

STATEMENT OF

POLLY SHACKLETON (D-Ward 3)

CHAIR, COMMITTEE ON HUMAN SERVICES
COUNCIL OF THE DISTRICT OF COLUMBIA

before the

COMMITTEE ON THE DISTRICT OF COLUMBIA

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

U. S. HOUSE OF REPRESENTATIVES

May 22, 1986

I am Polly Shackleton, Chairwoman of the Committee on Human Services of the Committee on Human Services of the Council of the District of Columbia. I appreciate the opportunity to appear before you once again on the subject of Saint Elizabeths Hospital and the development of a comprehensive mental health system, Mr. Chairman. I have been personally involved in discussions about this issue for more than 17 years, since 1969 when I was a member of the Rome Commission. I have frequently appeared before this Committee and before Congressional Appropriations Committees faced with difficult funding problems in the past.

I fully support the transfer of authority to the District Government for a comprehensive mental health system, and the creation of a Commission on Mental Health within the Department of Human Services to carry out the new responsibility. Many of the problems which have plagued the divided system over the years can be resolved by unifying and integrating services in this way.

My Committee held two days of public hearings in January, giving a broad opportunity to professionals and interested individuals and organizations to comment on the plan. It is clear that there is widespread support for the proposed

organization and structure of the Commission on Mental Health and for the principles which guide its emphasis on two principal groups of clients: children and youth, and chronically mentally ill adults.

My Committee also noted the widespread participation of many family members, professionals, and organizations in the development of the plan. This will ensure that our system is designed to meet the needs of our population and to achieve the goals set by the community for mental health services.

In the Resolution proposed by my Committee and passed by the Council on February 28, 1986, we noted several areas which needed further attention. We are particularly concerned about patients who have a dual diagnosis of mental retardation and mental illness, and about patients who are both mentally ill and substance abusing. In both of these areas more detailed proposals are necessary, and I am advised that MHSRO has established comprehensive task forces in both cases to provide us with the information and proposals we requested. We also requested detailed cost and revenue data in the Final Plan and are particularly interested in reviewing the financing of children's programs across the Department of Human Services and the Public Schools.

The District Council takes a keen interest in the development of plans for that part of the Saint Elizabeths campus which will not be used directly by the mental health system. The Mayor has now established a Task Force to assist him in the development of guidelines and proposals and we expect to review his recommendations in the fall.

But our deepest concern relates to the possibility that the federal government will not honor its November, 1984 agreement about the rate at which federal funds will be withdrawn from this system. Already in FY 1986 the imposition of Gramm-Rudman-Hollings cuts has removed nearly $4 million from promised payments to the Hospital. Such arbitrary changes in the carefully planned sequence of stepped-down payments, which allowed an orderly shift of responsibility from the federal to the District governments, can be very damaging to the District's ability to manage this transition smoothly. The process is a very complex one, and one to which a great deal of energy and careful preparation has been given.

I strongly urge you, Mr. Chairman, to prevent any further harm to this effort by an instruction from Congress to the federal executive to exempt from Gramm-Rudman-Hollings actions all payments associated with this transfer of authority. The federal appropriations to Saint Elizabeths are already

declining at the rate of $6 million a year under the existing agreement, and will end completely within five years. To disrupt this schedule, on which both executive branches and the Congress agreed in 1984, is a breach of faith which will place the transition process in jeopardy.

We also urge your attention and support for funding the renovation of the Saint Elizabeths facilities which will be transferred to the District. The federal government must not pass along to the District an unfinished commitment to bring these facilities up to appropriate treatment standards -- standards that will meet the test of accreditation. Your Committee took the lead in mandating the federal commitment to this renovation in 1976, Mr. Chairman, and I know we can count on you to pursue the task until it is complete.

In closing, let me repeat that the District Council is monitoring the development of this comprehensive mental health system for our community with care and diligence. We are satisfied that the work is proceeding on the required timetable, and is in full compliance with the mandates of P. L. 98-621 and with all applicable District statutes. We look forward to receiving the Final Plan from the Mayor in October of this year, and to supporting the assumption of full responsibility in October of next year.

Thank you for this opportunity to present our views to you this morning. We look forward to working with you in the implementation of a new mental health system which will meet the goals to which we are both so strongly committed.

Mr. FAUNTROY. I thank you so much, Ms. Shackleton. Let me just raise a couple of questions with you.

You held public hearings on the preliminary system implementation plan back in January, and you raised several concerns regarding the financial planning assumption that underlies Public Law 98–621. I wonder if you'd care to enlighten the committee further on the concerns you raised?

Ms. SHACKLETON. Well, principally, we—if the funding is cutback, in my view, there will be no way that the plan can be carried out as it has been put forth. It just won't be possible, and I think that's a very serious and critical situation if that does occur.

The District has made this commitment. The Federal Government has made its commitment. The District is keeping its commitment, and unless the funding is available, the full funding, something is going to have to go by the wayside. That will mean that the plan will not be achieved the way it should be.

Whether it will be care, patient care, outreach, whatever, some of these programs that Ms. Fleming has discussed with you simply cannot be carried out if the funding is not available. And you know as well as I know that the District is not going to be able to make up the difference.

Mr. FAUNTROY. I certainly hope, Ms. Shackleton, that as you've indicated you're going to remain active on this issue even beyond your retirement from the council. But I certainly would hope that you and others who have testified here will keep us abreast of the extent to which the commitments for capital improvements out there are being kept as we move toward the transfer date.

I must admit that the thing which perked my interest in the *Emory Lee* case immediately was the prospect that perhaps the heating system there was not being put in the proper condition, as we expect it to be when it is turned over. And while that may have been a factor in the whole situation there, I want to be sure that we get a first-class facility, as was committed by the Federal Government to us when we passed this law.

So, please, keep me abreast of that. That's a request I make of all of those who have testified here thus far.

My second concern has to do with the use of all the real property and buildings that will not be required. As you recall, under the law the Mayor is required to prepare and submit to the Congress a master plan for use of all that, and to tell us what uses we can expect of the land not transferred as a part of the plan we are hearing today.

I note in your testimony again on—your statement, really, on January 16, that you raised certain questions concerning the direction that the plan might take. Do you care to share with us some of those questions and concerns?

Ms. SHACKLETON. Well, as you may recall, in our hearings there were people who wanted to see that west part of the property used for further patient care for residents and so forth. I think there was strong testimony presented to our committee that did not support that concept.

In addition, I think the people in ward 8 also had some views. I know my colleague, Ms. Rolark, was not particularly intrigued by that idea, and I think she expressed the view that her constituents

in the area wanted to see some use made of that that would—that the whole community would be able to approve of and participate in and so forth.

We understand that there are a number of thoughts. Various groups are looking at different proposals, and that Mr. McClinton and his staff are studying them. We certainly will look at that very, very carefully, because I think it's going to affect a lot of people. It's going to affect the community, and I think a lot of good things can be done with that. It's a wonderful property, and I think some very favorable programs can be developed there.

So that is something that we will want to look at when we have our hearing in the fall later on.

Mr. FAUNTROY. Thank you so very much, Ms. Shackleton. We do have the proceedings of your hearings back in January.

At this point in the record, I want you to place—I want to direct staff to place both Ms. Shackleton's comments and Ms. Rolark's comments to which she referred in relevant part to that question.

Thank you so very much, and I appreciate not only your years of work but your persistence and consistency on this question.

Ms. SHACKLETON. Again, my thanks to you and best wishes.

Mr. FAUNTROY. Thank you.

[The attachment to Ms. Shackleton's statement follows:]

# Council of the District of Columbia
## Report

The District Building 14th and E Streets, N.W. 20004 First Floor 724-8000

DRAFT

To Members, Committee on Human Services

From POLLY SHACKLETON, Chairperson, Committee on Human Services

Date February 11, 1986

Subject Committee Report on PR 6-288, the "Preliminary System Implementation Plan for a Comprehensive District Mental Health System Recommendation Resolution of 1986."

The Committee on Human Services, to which PR 6-288, the "Preliminary System Implementation Plan for a District Comprehensive Mental Health System Recommendation Resolution of 1986," was referred, reports in favor of the bill and accompanying report and recommends their adoption by the Council of the District of Columbia.

LEGISLATIVE HISTORY

| | |
|---|---|
| January 3, 1986 | PR 6-288 is introduced by Chairman Clarke at the request of the Mayor. |
| January 3, 1986 | PR 6-288 is referred to the Committee on Human Services. |
| January 16 and 17, 1986 | Public Hearings on PR 6-288 by the Committee on Human Services. |
| February 11, 1986 | Consideration and mark-up of PR 6-288 by the Committee on Human Services. |

Background and Purpose

Years of intense debate about the governance of St. Elizabeths Hospital culminated in late 1984 with passage of P.L. 98-621, the "St. Elizabeths Hospital and District of Columbia Mental Health Services Act," in which Congress mandated that the District take over the federal hospital responsibility and create a comprehensive, coordinated, and community-based system over a six-year period. The Mayor created the Mental Health System Reorganization Office ("MHSRO") within the Department of Human Services to carry out the complex planning process which this reorganization requires. The Preliminary System Implementation Plan ("Plan") was developed in conjunction with over 400 persons, including families of the mentally ill, advocates, clients, and professionals.

P.L. 98-621 requires the Council to review the Plan and transmit written recommendations to the Mayor regarding any revisions within 60 days. The Mayor must then submit a revised preliminary plan to the Congressional oversight committees for review. The law also requires that a final system implemention plan in the form of a reorganization plan be submitted to the Council on October 1, 1986.

The Committee on Human Services has reviewed the Plan and testimony of government and public witnesses carefully. We commend the Executive, particularly the Mental Health Services Reorganization Office under the leadership of Virginia Fleming, for coordinating diverse professional and community views and producing such a comprehensive plan. The Committee print of PR 6-288 reflects the recommended revisions to the Plan which are discussed below.

In addition, the Committee has a number of general comments on the Plan and its financing. We support the establishment of a separate Commission on Mental Health and urge the Mayor to begin recruiting the leadership necessary to assure a successful transition immediately, although the Commission will not be formally established until the Council has completed its review of the final system implementation plan to be submitted October 1, 1986.

We also wish to indicate our strong support for the children's program. The plan provides a single focus of accountability for children's mental health services for the first time by placing them under the jurisdiction of a single administration. It acknowledges the current shortage of programs for youth and recommends the development of a full continuum of services with an emphasis on early intervention and outreach. The Committee also strongly supports the location of services for children and their families in schools, primary health care clinics, and churches. We are especially pleased that the needs of children at risk of being neglected have been addressed. The implementation of these plans, with the goal of reaching 2,200 children and their families in fiscal 1988 and some 6,700 by fiscal 1991, will require both a major commitment of resources and a level of interagency cooperation beyond that which the District's youth-serving agencies have demonstrated to date. The Committee is hopeful that the cooperation among public and private agencies evident in the planning effort can be sustained.

The success of the unified system depends on full funding during the transition period through fiscal year 1991. The federal government must honor the agreement reached when P.L. 98-621 was enacted regarding the shared responsibility for funding the mental health system during the transition period. Both the DHHS appropriation to St. Elizabeths and the special transition subsidy are vulnerable to Gramm-Rudman-Hollings cuts. Without full federal funding the city will be unable to accept full responsibility for the system.

The District government has made a tremendous commitment to increase funding for the new system during the transition period and in future years.

According to information supplied during the hearing, the net District cost will increase as follows (in millions):

| FY 87 | FY 88 | FY 89 | FY 90 | FY 91 |
|---|---|---|---|---|
| $59.5 | $73.3 | $89.3 | $100.3 | $111.3 |

Lack of budget detail in the Plan makes it impossible to evaluate the proposed system's financial feasibility. The Committee is particularly concerned that the plan appears to propose a no-growth budget from fiscal years 1987 through 1991. The out-year figures are based on assumptions regarding economies that may not be achievable; and, therefore, proposals to deliver services for twice as many adults and five times more children and families than are currently served seem unrealistic.

The Committee supports the Mayor's position on seeking continued federal support for capital funds necessary to complete the east side renovation program begun a decade ago and for the NIMH pre-service training programs which have made such an important contribution to the quality of public and minority psychiatry nationwide. Although an additional $44 million is required to complete renovation of patient-care buildings, only $10 million of the original appropriation remains. The federal government is responsible for assuring that the hospital complies with code and accreditation requirements and meets reasonable efficiency standards. The District can only accept responsibility for the national institution if the federal government meets this responsibility.

The plan anticipates that about 700 persons will need supervised or supported housing in the community by fiscal year 1991: 300 Dixon class patients currently at St. Elizabeths; 200 mentally ill homeless persons needing organized group programs; and 200 previously independent or in-family patients now needing supported homes. The Plan recognizes that neighborhood acceptance of new residential programs is limited in the District, particularly with other court-mandated classes being placed in communities with limited housing stock. It notes, however, that there are currently about 200 vacant beds in existing community residence facilities (CRFs) that can be utilized and emphasizes alternatives to CRFs such as supervised apartments and foster care. The Committee received testimony from several non-profit groups that have had considerable success placing chronically ill patients in private apartment stock (with 24-hour support available for crises) because landlords are eager to have rent guaranteed. The Committee believes that community support will have to be carefully developed if this ambitious plan is to be realized. Since the system depends on the savings generated by the lower cost of community care, it is important that these goals be met.

We recommend that the Mayor make the following revisions to the plan before submitting it to the Congressional oversight committees:

1. P.L. 98-621 mandates that the Mayor propose a land use plan on or before October 1, 1991, for those portions of the St. Elizabeths campus that

are not needed for purposes related to mental health or human services. This plan requires input from appropriate local, regional, and national authorities, and Congress must enact it before the transfer of any property rights. Our Committee is concerned about the lack of specificity in the plan and asked the Executive for more details about the process the Mayor to use in developing possible alternative uses for the West Side. In his testimony, Mr. David Rivers, Director of DHS, indicated that the Executive plans to develop specific land-use criteria and to solicit bids for the proposed uses with the expectation that preliminary recommendations will be prepared for the Mayor's consideration by fall. Chairperson Shackleton emphasized the importance of designing a process to solicit community input into these decisions. She asked for and received a commitment that a public hearing will be held. The Committee emphasizes the importance of the west side deliberations being open to all interested persons.

Two important issues surfaced at the Committee's hearings regarding the use of the west side. First, the possible use of the land for "transitional" living arrangements for patients was suggested. While not ruling out some patient uses, the Committee joins the Mental Health Law Project and others in cautioning that living arrangements on the grounds of the state mental hospital for patients eligible for outplacement under the Dixon decree would not meet the Court's mandate. And second, some observers have suggested that if the West side is sold or developed, the proceeds, or some portion thereof, should be held in trust for the mental health system. While the Committee strongly supports full funding for the new unified system, it does not support dedicating revenues.

2. The Committee is seriously concerned about the proposed 150-bed facility for mentally retarded clients at St. Elizabeths. The planning to date for these persons has been inadequate. We join the D.C. Association for Retarded Citizens in urging that the Mental Health Services Reorganization Office establish a planning group immediately to advise it on conducting a review of the diverse needs of these clients and on the design of appropriate programs.

3. The Committee believes that the Executive should include the Alcohol and Drug Abuse Administration (ADASA) in the proposed Commission on Mental Health. Clearly many mentally ill individuals suffer from alcoholism or other substance abuse. Frequently, mentally ill substance abusers are among the most dangerous mentally ill and the long-term mental health problems caused by PCP will certainly continue to require special programs. Including ADASA in the new Commission seems the best way to assure proper coordination of these programs.

4. The Committee has some concerns about plans to have the Adult Services Administration provide outpatient services to mentally ill clients who are conditionally released from the criminal justice system. While linking some forensic clients to community mental health services will be appropriate, the judiciary must have a high degree of confidence in the follow-up services for these persons if they are to grant timely releases. Some capacity should be

maintained in the Forensic Services Administration for clients requiring specialized outpatient services.

5. Efforts to serve the homeless mentally ill (and to prevent chronically ill persons living in the community from becoming homeless) rest with adequate crisis resolution and outreach services. Although the plan makes provision for these services, we have reservations about the proposed 1:40 staff/client case management ratio, particularly for clients who are experiencing difficulty in the community. The District also has a responsibility to assist homeless persons in obtaining benefits to which they are entitled. Accessing benefits is important for system revenues as well as individual clients, since all SSI recipients are automatically eligible for Medicaid, and Veteran's benefits often provide disability payments and health benefits if the disability can be established as service related. The Committee is aware that the Health Care for the Homeless Project has been successful in designing an SSI project and in obtaining a commitment from the Veteran's Administration to research the service history of each homeless person brought to their attention and to provide the necessary forms to project staff. The District should aggressively follow through on these efforts with respect to all homeless individuals and families.

6. The ability of the Department of Human Services' support services to handle such an enormous system and the impact of the reorganization on other District agencies must be carefully examined. The Committee would like to see these questions addressed in the final system implementation plan. We are particularly concerned about how procurement, budgeting, and other support functions will be handled for the hospital. What impact will there be on the DHS Personnel Cluster, the Department of Administrative Services, and other affected agencies? The Department of Consumer and Regulatory Affairs will require additional resources by fiscal year 1988 to regulate additional community-based residential facilities. To the extent that new regulatory and financing mechanisms must be established or current law amended, the Council urges that the necessary legislative proposals be forwarded as soon as possible.

7. The Committee expects to receive a detailed budget proposal as part of the final system implementation plan to be submitted October 1, 1986. Both revenue and cost assumptions must be developed in detail. Policy changes which would maximize Medicaid revenue should be carefully analyzed before development of the revenue budget.

8. The Committee believes that the proposal to transfer funds to other administrations within the Department of Human Services ($6,000,000 to the Mental Retardation and Developmental Disabilities Administration and $5,000,000 to the Long Term Care Administration) does not assure adequate control of programs and funds by the mental health system. Many patients need nursing home care or special programming designed for dual diagnoses, however transferring these funds and the responsibility for the care of these patients to other administrations could force mentally ill clients to compete with other pressing needs and create serious continuity-of-care issues should these clients require acute mental health services at a future date. If the

operation of discrete programs by another administration seems appropriate, intradistrict sales agreements could be executed. We have similar concerns regarding the proposed transfer of $20,500,000 to the Department of Public Works unless its responsibilities are spelled out in detail.

9. There are a variety of complex financing issues surrounding the children and youth services budget due to the multi-million dollar resources for mental health and related services that are currently located in the Commission on Social Services' and D.C. Public Schools' budget. Discussions among the D.C. Public Schools, DHS, and the courts regarding responsibility for serving emotionally disturbed youth who are not considered educationally handicapped under P.L. 94-142 have proven inconclusive. Issues of financial responsibility and budget and program authority must be resolved, particularly since the Plan proposes the development of residential service capacity in the Child/Youth Services Administration of the mental health system.

10. The success of the new system will depend on its staff and their ability to carry out new job descriptions. We understand that the MHSRO has developed proposed staffing patterns which are currently being reviewed. Closure on these issues is essential to further planning. The Plan makes a commitment to staff development, including in-service training and the retraining necessary to assure the success of the transition. The Committee expects the training budget to be spelled out in the final system implementation plan.

## Section-by-section Analysis

Section 2 states the Council's findings concerning the process of Mayoral submission and Council review of the preliminary system implementation plan pursuant to P.L. 98-621.

Section 3 expresses the Council's recommendations regarding revisions to the preliminary system implementation plan and expectations for the final system implemenation plan to be submitted to the Council on October 1, 1986.

Section 4 requires the Council to transmit a copy of PR 6-288 to the Mayor upon adoption.

Section 5 is the effective date provision.

## Impact on Existing Law

PR 6-288 is in conformance with the provisions of P.L. 98-621 which requires that the Mayor submit to the Council a Preliminary System Implementation Plan and that the Council review the Plan and transmit written recommendations to the Mayor within 60 days.

## Fiscal Impact

The preliminary plan has no fiscal impact per se, however, financing the mental health system during the transition period and in the future will require the District government to significantly increase the portion of mental health services funded by local sources. The Committee remains concerned about the assumption of no real growth in total system cost during the transition period.

Mr. FAUNTROY. We're going to ask our next panel, Dr. Steven Sharfstein, the deputy medical director of the American Psychiatric Association, and Dr. William Carr, of the District of Columbia Psychological Association and the American Psychological Association, to come.

Gentlemen, I have to move on to a funeral which I must attend. I'm a little late for it, but I must go; and I'm going to ask if the staff would conduct the hearings at this point until I can return.

Thank you.

## TESTIMONY OF STEVEN S. SHARFSTEIN, M.D., DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. SHARFSTEIN. We'll miss you, Mr. Chairman.

My name is Steven Sharfstein, and——

Mr. WILLIS. I don't know whether to say thank you or not, Steven.

Mr. SHARFSTEIN. We're glad you're here, Ron. I am deputy medical director of the American Psychiatric Association, a medical speciality society representing over 32,000 psychiatrists nationwide.

I appreciate very much this opportunity to comment on the District of Columbia's mental health preliminary system implementation plan. In my statement, I associate myself with the views and recommendations of the Washington Psychiatric Society, its D.C. chapter, and the Physicians Association of St. Elizabeths Hospital, particularly with respect to plan implementation at the local level.

I will abbreviate my remarks. You have the complete comments for the record.

At the outset I want the committee to know that I feel there are many positive aspects to the District's plan. I will focus my remarks, however, on where the plan is weak or overly ambitious, with the hope of changing it and ameliorating the deficiencies in it.

For purposes of providing you with a summary of our recommendations, they are as follows:

There is a need for, first, stated guiding principles to aid development of a high quality and comprehensive system of care; second, continued asylum at the hospital for some chronic patients.

Third, pilot projects with D.C. community hospitals to test the feasibility of shifting patients to these facilities. Fourth, adequate insurance coverage of mental disorders in the District. Fifth, attraction and retention of capable and committed physicians. Sixth, a merging of alcohol and drug abuse services into the mental health commission.

Seventh, continued stable fiscal support for research and training programs at the hospital. Eighth, special attention to the urban homeless. Ninth, a moratorium on the planning for the west side of the hospital grounds.

With the signing of the law, Public Law 98-621, and the establishment of the District's Mental Health System Reorganization Office, an important initial step has been reached in the development of the unified system. Through our representatives to that office, we continue and look forward to continue to work for the development of a plan responsive to the intent of Congress, and I quote, which is to quote:

* * * develop a comprehensive mental health care system including high quality, cost effective, community-based programs and facilities; inpatient and outpatient programs; residential treatment programs; and support services, all of which guarantee the protection of patient rights and medical needs.

We emphasize Congress' recognition of the importance of this medical needs criteria, since proposed management changes are of value only to the extent that they help the patients they serve. As physicians, we believe that a plan designed to care for ill people should be based on clinical criteria.

In this context the most important guiding principles facing the commission should be: One, to enable those who are mentally ill to receive the best treatment available; and two, to ensure that those persons whose primary need is for long-term care and treatment will have access to the most appropriate treatment.

Given this framework, you must know that not all of the psychiatrically ill in the 1980's can be successfully treated to where their behavior will be completely acceptable in community settings. Accordingly, the plan should admit explicitly that some patients need asylum, and that asylum should not be in the streets.

While many of the very chronically mentally ill can be managed in small group homes, others have their greatest freedom from their illness and the consequences of their illness when they are living on the grounds of the hospital. The St. Elizabeths grounds is part of a full continuum of care which will help make the community residential facilities a success by their not having to care for all these patients.

By having an asylum program on the grounds of St. Elizabeths, rehabilitation programs will not be frustrated with these patients, and the patients will not have to suffer the pains of being part of a rehabilitation program that's not working for them.

Asylum for some allows community care for the many.

The District's plan speaks to the development of a full continuation of culturally appropriate, community-based programs designed to serve the needs of the people of the District of Columbia. We applaud this commitment. We remain concerned about whether the envisioned community-based system can be fully realized within the stated timeframe.

The District's plan itself recognizes this by stating that the potential for community-based care for the chronically mentally ill has not been fully realized because the support system which the State hospital provides has not always been replicated in community settings.

We urge the District to proceed carefully and to work closely with knowledgeable medical professionals at St. Elizabeths in implementing this transition.

The plan envisions significantly greater reliance on adult acute care psychiatric beds in seven Washington community hospitals without providing any evidence that these units want to assume responsibility for the very dangerous or the very disabled patients that constitute many of St. Elizabeths' admissions.

The District acknowledges in its report that "the exact number of non-St. Elizabeths Hospital psychiatric beds is difficult to determine" and, more importantly, that "private providers may lack interest or skills in treating the most destitute and chronically ill."

These appropriate limitations make proper planning and evaluation critical.

Even if the psychiatric units are willing, the plan appears to call for discontinuity of patients crossing back and forth between public and private sectors. We agree then with the physician staff of the hospital, of St. Elizabeths, that contracting for acute inpatient psychiatric treatment should be piloted first to iron out some of these difficulties before it is replicated on a massive scale.

It is estimated that 450,000 citizens in the District have some form of health insurance. With few exceptions, the coverage of psychiatric services in those plans is very inadequate. We feel the plan should speak in favor of requiring adequate insurance coverage for District citizens who have mental illness.

It is unconscionable, we feel, for the District's plan to be silent on this discrimination. The commission of mental health should regard it as his or her responsibility to pursue satisfactory mental health coverage in health insurance plans in the District of Columbia.

A major assumption on the part of the District is that many patients who presently reside at St. Elizabeths might be able to live in less restrictive settings such as the District licensed community residential facilities or CRF's. We urge the District to proceed cautiously on expanding the use of CRF's.

It is important that CRF's be used like any other major treatment approach, with the uses, cautions, contraindications explicitly established. For some patients, CRF's provide the appropriate least restrictive setting. For other more disabled or more dangerous patients, the skills and structure of a CRF are too limited. Besides protecting the patients, careful use of CRF's will help forestall community opposition to their development.

A recognition that some severely chronically ill patients need the asylum of St. Elizabeths helps make CRF's a success by not placing those patients in those facilities. Otherwise, we feel that the patients, the public, and the mental health system suffer a false optimism.

Over 100 psychiatrists at St. Elizabeths, the majority of whom are board certified, have made great contributions to patient care, research and training at the hospital. The plan should respect the judgments of concerned and knowledgeable clinicians about the needs of these patients—of their patients—and retain these clinicians in the new system.

No physician has assurance that he or she will have a position in the new system. More needs to be said about the staffing patterns and about inducements to attract and retain well trained and well motivated clinicians.

We would recommend further that a clear accountability be assured for each patient for adequate psychiatric diagnosis, care and treatment. Both to serve more patients with fewer staff and to serve more patients in an outpatient setting requires greater skills from clinicians. Under such circumstances, it is important that each patient have a complete evaluation by a psychiatrist and an individual treatment plan that is consistent with the psychiatrist's findings.

To achieve this goal, there should be adequate psychiatric staffing and monitoring. The plan perceives the address and length of patient stay as important characteristics in determining programmatic decisions. Diagnosis and treatment goals that clinicians have for patients are not mentioned in the plan. The plan emphasizes level of care needed along functional lines rather than level of care based on diagnosis and clinical needs.

Although functional status and disease relate, it is difficult, if not impossible, to prescribe a care plan without both. Many patients need highly specialized care and treatment, since they have illnesses that, as a rule, will respond poor to less specialized treatment.

In addition, while the plan speaks of the importance of an integrative approach, it removes from a single commission those who suffer from the largest single admission category, alcoholism. It removes those mentally ill with substance abuse, the most dangerous of the mentally ill, and leaves them in a separate commission.

We believe that the Alcoholism and Drug Abuse Services Administration should be part of the commission on mental health. Anyone serving patients admitted to public psychiatric programs knows that many patients have alcoholism and substance abuse along with other psychiatric illnesses. It does not make clinical sense and less administrative sense to have responsibility for these patients in two separate commissions. It would be difficult to imagine that coordination between these two commissions will adequately serve these patients.

During our appearance before the Congress prior to enactment of Public Law 98-621, we stressed the importance of both Federal and District government support for clinical psychiatric research and related federally supported patient services, as well as professional clinical training. A combined Federal and District investment in these ongoing research, service and training programs will increase the city's capacity to develop greater knowledge about mental illness and to facilitate growth of treatment programs, especially treatment programs for the most severely ill.

Consistent with the requirements of Public Law 98-621, special attention should be devoted to the urban homeless. This is needed to learn how the psychiatrically ill can avoid becoming part of the city's homeless population. These problems are nationwide in scope and should be resolved with continued Federal support for research and training.

There needs to be a focus upon clinical research and training that will prevent the mentally ill from becoming abandoned on our city streets. We look forward to receiving more information on the District's commitment to these important activities. Moreover, we would welcome suggestions about continued Federal support of research and training.

We agree with the Mayor's letter to Congress calling for Federal support of training. There is a need for congressional support of training. In Public Law 98-621, Congress call for continued Federal support of training. Training at St. Elizabeths has been a Federal magnet that has attracted high quality staff, has attracted minority trainees in unusually large numbers, has at-

tracted people who have become hospital, local and national mental health leaders.

Federal support of training has been a conduit and catalyst for current and innovative treatment for the mentally ill. Saint Elizabeths' training programs have enhanced the knowledge and skill of every clinician who serves any of the hospital's patients. Relative to innovative approaches, training at St. Elizabeths in establishing new psychotherapeutic treatments in the 1940's, in understanding new psychopharmacological therapies in the 1950's, in developing community psychiatric programs in the 1960's, in comprehending new diagnostic entities in the 1970's, and in expanding outreach psychiatric services to the homeless in the 1980's.

This Federal legacy has been a key element in St. Elizabeths' sense of pride and worth. At a cost of only $5 million annually, this Federal legacy can continue as an expression of congressional wish that the Nation's Capital's most dangerous, most disturbed and most disabled mentally ill receive the highest quality services.

Finally, a major resource for the mentally ill for the past 131 years in the District of Columbia has been St. Elizabeths grounds. Such a resource should remain available to the mentally ill until it has been proven that it is not needed. We have no quarrel with the concept of having the hospital only occupy the east side, but other nonhospital programs may be needed on the west side.

Nonhospital needs, asylum programs, group home programs, shelter workshops, recreational programs could all become important elements for the mental health system in the 1990's, programs that could logically be placed on the west side of the grounds. It would be tragic to throw away a major resource.

Therefore, we propose a moratorium on any plan for the development of the west side until other crucial issues are resolved, including patient placement throughout the District of Columbia.

We appreciate this opportunity to comment on the plan, look forward to working with the District of Columbia and the Federal Government during this transition period.

Thank you.

Mr. WILLIS. Thank you, Dr. Sharfstein.

[The prepared statement of Dr. Sharfstein follows:]

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STATEMENT OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON

"SAINT ELIZABETHS HOSPITAL AND DISTRICT OF COLUMBIA
MENTAL HEALTH SERVICES ACT"

PRESENTED

BY

STEVEN S. SHARFSTEIN, M.D.
DEPUTY MEDICAL DIRECTOR

BEFORE THE

COMMITTEE ON DISTRICT OF COLUMBIA
SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

MAY 22, 1986

Mr. Chairman, I am Steven S. Sharfstein, M.D., Deputy Medical Director of the American Psychiatric Association, a medical specialty society representing over 32,000 psychiatrists nationwide. I appreciate this opportunity to comment on the District of Columbia's Mental Health Preliminary System Implementation Plan. In my statement, I will also associate myself with the views and recommendations of the Washington Psychiatric Society and the Physicians Association of Saint Elizabeths Hospital, particularly with respect to plan implementation at the local level.

At the onset I want the Committee to know that there are many positive aspects to the District's plan. I will focus my remarks, however, on where the plan is weak or overly ambitious, with the hope of ameliorating the perceived deficiencies. For the purpose of providing you with a summary of our recommendations, they are as follows. There exists a need for:

- stated guiding principles to aid development of a high quality and comprehensive system of care;
- continued asylum at the Hospital for some chronic patients;
- pilot projects with D.C. community hospitals to test feasibility of patient shifts;
- adequate insurance coverage of mental disorders in the District
- attraction and retention of capable and committed physicians;
- a merging of alcohol and drug abuse services into the Mental Health Commission;
- continued stable fiscal support of research and training programs;
- special attention to the urban homeless;
- appropriate utilization of the Hospital grounds.

I would now like to elaborate on these points and emphasize the issues of national significance which, in the APA's judgment, are critical to the design

and implementation of a comprehensive mental health system, including Saint Elizabeths Hospital, for the residents of the District of Columbia. As you know, this hospital's contribution to the care and treatment of its psychiatric patients has been exemplary in comparison to many other public psychiatric hospitals and hence, the statutorily-required transfer of the Hospital to the District must be planned in such a way to assure that the care and treatment of psychiatric patients is enhanced, not harmed.

As stated during my two appearances in 1984 before your Committee, the APA believe that the test of any acceptable resolution to the problems facing Saint Elizabeths Hospital, should, in our view, be based on the following considerations:

- the availability in the District of Columbia of a full range of services -- both hospital and community-based -- appropriate to the needs of the city's mentally ill;
- the quality of these services at no less than the current best capability of the mental health field;
- service provision through a unified delivery system with upwardly converging lines of professional and managerial accountability;
- ready and flexible access by patients to different combinations of services as their changing clinical and social status may require; and
- flexible deployment of staff, and emphasis on continuity of care consistent with individual treatment plans.

With the signing into law of the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act (P.L. 98-621) and the establishment of the District's Mental Health System Reorganization Office, an important initial step has been reached in the development of a unified system. Through APA's representatives to that Office, we will continue to work for the

development of a plan responsive to the intent of Congress, e.g.

> "that the District of Columbia have in operation no later than October 1, 1991, a comprehensive mental health care system which includes high quality, cost-effective community-based programs and facilities; inpatient and outpatient care programs; residential treatment programs; and support services, all of which will guarantee the protection of patient rights and medical needs."

We emphasize Congress' recognition of the importance of this "medical needs" criteria, since proposed management changes are of value only to the extent that they help the patients they serve. As physicians we believe that a plan designed to care for ill people should be based on clinical criteria. In the May 1986 edition of Hospital and Community Psychiatry, Leona L. Bachrach, Ph.D. discusses one loci of "medical needs" care which is appropo of the pending matter, as follows:

> "Although the program needs of individual chronic mental patients vary considerably, many of these patients require long-term care, often in structured service settings. They often need a vast array of residential, treatment, and transportation services that may only be described as total care. However, because state mental hospitals have frequently been emasculated or even totally destroyed before a sufficient array of community services has been assured, the problems of providing needed care -- at least on a nationwide basis -- appear to outweigh service systems at the present time. The simple fact is that there is often no place in our system for patients who are seriously ill and in desperate need of treatment."

She concludes that "far from being moribund facility, the state mental hospital will continue to occupy an important niche in the psychiatric service system so long as it supplies unique services to chronic mental patients -- services that they need but do not receive elsewhere."

In this context the most important guiding principles facing the Commission must be (1) to enable those who are mentally ill to receive the

best treatment available and (2) to ensure that those persons whose primary need is for long-term care and treatment will have access to the most appropriate treatment facilities. Given this framework, you must know that not all of the psychiatrically ill in the 1980's can be successfully treated to where their behavior will be acceptable in community settings. Accordingly, the plan should admit that some patients need an asylum and that asylum should not be in the streets. While many of the very chronically mentally ill can be managed in small group homes, others will have their greatest freedom from their illness and the consequences of their illness when they are living on the grounds of Saint Elizabeths. The Saint Elizabeths grounds is part of the full continuum of care which will help make community residential facilities a success by their not having to care for such patients. By having an asylum program on the grounds of Saint Elizabeths, rehabilitation programs will not be frustrated with these patients and the patients will not have to suffer of the pains of being part of the rehabilitation programs that are not working for them.

The District's plan speaks to the development of a full continuation of culturally appropriate, community-based programs designed to serve the needs of the people of the District of Columbia. While we applaud this commitment, we remain concerned about whether the envisioned community-based system can be fully realized within the stated time frame. The District's plan itself recognizes this stating, "the potential for community-based care for the chronically mentally ill has not yet been fully realized" because "the support system which the state hospital provides . . . has not always been replicated in community settings." We urge the District to proceed carefully and to work closely with the knowledgeable medical professionals at Saint Elizabeths in implementing this transition.

The District plan envisions significantly greater reliance on adult acute psychiatric beds in seven Washington community hospitals without providing any evidence that the psychiatric units of community hospitals in the District will want to assume responsibility for the very dangerous or the quite disabled patients that constitute many of Saint Elizabeths' admissions. The District acknowledges in its report that "the exact number of non-Saint Elizabeths Hospital psychiatric beds in difficult to determine" and more importantly that "private providers may lack interest or skills in treating the most destitute and chronically ill." These limitations make proper planning and evaluation critical. Even if the psychiatric units are willing, the plan appears to call for discontinuity of patients crossing back and forth between the public and private sectors. We agree with the physician staff of Saint Elizabeths Hospital that contracting for acute inpatient psychiatric treatment should be piloted first to iron out some of the difficulties before it is replicated on a massive scale.

It is estimated that 450,000 citizens in the District of Columbia have some form of health insurance. With very few exceptions, the coverage of psychiatric services in those plans is inadequate. We feel the plan should speak in favor of requiring adequate insurance coverage for District citizens who have mental illness. It is unconscionable for the District's plan to be silent on this discrimination. The Commissioner on Mental Health should regard it as his or her responsibility to pursue satisfactory mental health coverage in health insurance plans in the District of Columbia.

A major assumption on the part of the District is that many patients who presently reside at Saint Elizabeths might be able to live in "less restrictive settings" such as District-licensed Community Residential Facilities (CRF) and supported apartment programs while they receive

treatment. We urge the District to proceed cautiously on expanding the use of CRFs. It is important that CRFs be used like any other major treatment approach, i.e. that the uses, cautions and contraindications be established. For some patients, CRFs provide the least restrictive setting. For other more disabled or more dangerous patients, the skills and structure of a CRF are too limited. Besides protecting the patients, careful use of CRFs will help forestall community opposition to the development of CRFs. A recognition that some severely chronically ill patients need the asylum of Saint Elizabeths grounds helps make CRFs a success by not placing those patients in CRFs. Otherwise, we feel that the patients, the public and the mental health system will suffer from a false optimism.

The over 100 psychiatrists, at Saint Elizabeths Hospital, the majority of whom are Board certified, have made great contributions to patient care, research and training at the Hospital. The plan should respect the judgments of concerned and knowledgable clinicians about the needs of their patients and retain these clinicians in the New System. No physician has assurance that he or she will have a position under the new system. More needs to be said about staffing patterns and about inducements to attract and retain well trained and well motivated clinicians.

We would recommend clearer accountability that assures that each patient has adequate psychiatric care and treatment. Both to serve more patients with fewer staff and to serve more patients in an outpatient setting requires more skill on the part of clinicians. Under such circumstances it is important that each patient have a complete evaluation by a psychiatrist and an individual treatment plan that is consistent with the psychiatrist's findings. To achieve this goal there must be adequate psychiatric staffing and monitoring. The plan perceives address and length of inpatient stay as

important characteristics in determining programmatic decisions. Diagnosis and treatment goals that clinicians have for patients are not mentioned in the plan. The plan emphasizes level of care needed along functional lines rather than level of care based on clinical needs. Although functional status and disease relate, it is difficult if not impossible to prescribe a care plan without both. Many patients need highly specialized care and treatment since they have illnesses that as a rule will respond poor to less specialized treatment.

In addition, while the plan speaks of the importance of the integrative approach, it removes from a single commission those who suffer from the largest single admission category, alcoholism. It removes those mentally ill with substance abuse, the most dangerous of the mentally ill, and leaves them in a separate commission. We believe that the Alcoholism and Drug Abuse Services Administration should be part of the Commission on Mental Health. Anyone serving patients admitted to public psychiatric programs knows that many patients have alcoholism and substance abuse along with other psychiatric illnesses. It does not make clinical sense to have responsibility for these patients with two separate commissions, and it would be difficult to imagine that coordination between these two commissions will adequately serve these patients.

During our appearance before the Congress prior to enactment into law of P.L. 98-621, we stressed the importance of both Federal and District government support for clinical psychiatric research and related Federally-supported patient services as well as professional clinical training. A combined Federal and District investment in these ongoing research, service and training programs will increase the city's capacity to develop greater knowledge about mental illness and to facilitate growth of treatment programs,

especially treatment programs for the most disabled mentally ill. Consistent with the requirements of P.L. 98-621, special attention should be devoted to the urban homeless. This is needed to learn how the psychiatrically ill can avoid becoming part of the city's homeless people. These problems are nationwide in scope and should be resolved with continued federal support of research and training. There needs to be a focus upon clinical research and training that will prevent the mentally ill from becoming abandoned on our city streets. We look forward to receiving more information on the District's commitment to these important activities. Moreover, we would welcome suggestions about continued Federal support of research and training.

Firally, a major resource for the mentally ill for the past 131 years in the District of Columb a has been Saint Elizabeths grounds. Such a resource should remain available to the mentally ill until it has been proven that it is not needed. We have no quarrel with the concept of having the "hospital" only occupy the East Side, but other non-hospital programs may be needed on the West side. Non-hospital needs, asylum programs, group homes, shelter workshops, recreational programs could all become important elements for the mental health system of the 1990's, programs that could logically be placed on the west side of the grounds. It could be tragic to throw away a major resource, the West Side of the grounds. While the Plan insinuates at times that it might reluctantly have to utilize the West Side of the grounds, the tone would better be one of looking forward to utilizing the West Side of the grounds if that can be done to the benefit of the psychiatrically ill, and it should remain a resource until there is certainty about it not being needed.

We appreciate this opportunity to comment on this plan and look forward to working with the District of Columbia and the Federal Government during the transition period.

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Mr. WILLIS. Dr. Carr, we will take your testimony now, sir.

**TESTIMONY OF WILLIAM E. CARR, PH.D., THE DISTRICT OF COLUMBIA PSYCHOLOGICAL ASSOCIATION AND THE AMERICAN PSYCHOLOGICAL ASSOCIATION**

Mr. CARR. Thank you, Mr. Chairman.

The D.C. Psychological Association and the American Psychological Association, which I am privileged to represent here today, certainly are appreciative of this opportunity to come before you. Since you have a copy of our statement now before you, I shall not read it, but there are certain parts of that statement that I want to extract at this particular time, to take out of context but certainly not out of significance and importance to bring to the attention of the board.

As you well know, there are some 67,000 members. That's a lot of people whom I'm representing here today, and DCPA is very happy that our professional associates here have come to the aid—and I am going to say specifically now psychologists in this endeavor and the role which they are playing in the implementation of this act.

We need to congratulate the subcommittee on the passage of Public Law 98-621, but what is more reassuring, from my point of view, as I reflect the thinking of my colleagues, is the fact that you are going to monitor this particular measure until it is fully implemented along the line.

DCPA has been responding to mental illness for a long period of time in the District of Columbia. Personally, I've had the privilege of being around here for about 50 years now, and have reached the statutory limit here, I suppose, of ineffectiveness in the minds of some people. However, in that period of time, I want to point out that, as we all know, mental problems, mental illness, which we have been dealing with, stemming from such things as domestic strife, prejudice, discrimination, poverty, and a number of other parameters here, are still with us. They hang around our necks like an albatross, and it is the legacy of this evil that we are referring to at this particular time, and we are happy that something is going to be done about it. We hope that whatever is going to be done is going to be done in the proper way.

Now then, I propose to bring before your attention in the nature of a constructive critique of the plan. That is, we are going to point out—we, being DCPA and APA. We are going to point out the outstanding achievements of the plan, but at the same time we are going to criticize what we perceive to be the need—to bring to your attention the need for revisions, the need for improvements in this particular plan.

We're happy to know and to observe that there has been the utilization of national expertise and a local expertise in addressing itself to the twin problems of the chronically mentally ill and the children. This is commendable.

We're also happy that there is a comprehensive care plan now in effect in which we are going to be treating alcoholism and drug abuse and so forth. We're even happier to observe that the geographical decentralization of a plan which reaches out into the community in all the quadrants in the District of Columbia here,



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maximizing the services of a plan to the system, maximizing the access to the system. We're very happy about that.

Research and training is most important, in our thinking; and there is a Federal intervention here which we want to bring to the attention of the committee because without this Federal support, you certainly cannot expect to continue research and training. And I think I might say as an aside at this particular time, at St. Elizabeths, there is a discussion group there under the sponsorship, the leadership, of psychologists who train a large number of people who we shall call health providers. These include social workers, psychiatric social workers, psychologists, students, graduate students, and others, offering all of these services which are most important. We certainly would hope that these kinds of services would continue.

Now let us get to some of the perceived flaws and problems. One of these perceived flaws is that the projections rely too heavily—projections of the plan rely too heavily on outside models. We should prefer that some type of retroactive approach be used in which perhaps the District would be used as its own control, rather than bringing in information from cities, from corporate entities, from rural parts of the country and that sort of thing and attempting here to say, we're going to model our plan on them; because the problems that we have in the District of Columbia are germane to the District. So we need to look specifically at what is happening here in the District.

A lot has been said about this theoretically oriented system, but certainly we must know, and I bring to your attention, that there is a big gap between a theoretically oriented system and a practical implementation of that plan, which has certainly been highlighted by speakers here who have preceded me.

The lack of minute detail in the plan bothers us, to some extent, because we do not know—it is not expressly pointed out in the plan—who, what, where, and how of operations which are going to take place. We need to know something about those operations. We don't think at all that it is premature to lay out in very clear form how this operation is going to take effect.

The blueprint is a vast, complex, and difficult one to comprehend, even from the professional level. So we are concerned again whether this is going to have some impact upon those people who are going to be receiving its services. We think something more ought to be done.

Now we are concerned whether we're going to be able to follow the patients, the patients who are leaving St. Elizabeths Hospital whether they are patients who are outside St. Elizabeths Hospital at the present time—to follow their care down to a definitive point of view where all of the inputs of any professional level, which may be going on there, are going to be consistent that will gain the confidence, which will certainly be conducive to here the healing of the people whom we are going to be serving. So we're concerned about that.

Much has been said about the west side. At this particular time, I want to include in the record a statement which reflects our point of view. It has been said that those who argue for the sale of the west side justify it on premises which lack merit. The first premise

is that 800 patients can be safely moved to community residential facilities, CRF's. Now we have some doubt about whether that can be done.

It is said by some that the west side exercises a certain kind of stigma in the community. Well, we think that the stigma is in the eyes of the beholder. So we want to say now that we hope that the west side will be left intact at the present time until we are certain that, after or subsequent to the implementation of this plan, it is no longer needed. So we certainly want to be certain that we keep that in mind, as others have said.

Now I get to a situation here which, of course, I can speak from experience and from which I could speak from my heart. That is the utilization of the psychologists. We're concerned. I think that you will understand why we are concerned.

The full expertise of psychologists has not been spelled out in the way that we should like to see it in the plan, specifically, in terms of leadership, in terms of policy making, in terms of program directors. We would like to see a clearer delineation with respect to the use of psychologists.

Psychologists are, from their professional training, well able and should be able to admit people to the system. They should be able to diagnose people. They should be able to write orders, and they should be able to treat and to discharge. We hope that at every level in this plan—and I shall not delineate the various levels at this time. But we hope that at every level in this plan that specific attention will be applied to the professional skills that psychologists bring and have at their hand in this particular endeavor.

The presence of psychologists, of course, as I've said, is conspicuous by their absence. There is, however, a law—and I have a copy of it which I'm going to introduce into the record here and leave it for you to peruse. We have the basis in law here for the utilization of psychologists here in the District of Columbia Health Occupations Revision Act of 1985, this big document, and we hope that some attention will be paid to that.

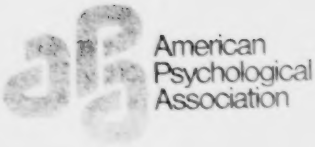
Now as I said before, that we hope that psychologists will be attended to at the senior levels in this plan across the plan laterally and in depth, because unless that is done, we feel that a continuity of service that has been established now and that is in place at the present time is not going to follow patient—is not going to be attendant to the patient throughout the terms of the patient's treatment here and throughout the terms of the patient's repair.

Now I want to get to the summary at this time, and to point out again to the committee that, while we are happy, while we are most appreciative of what has been done, we would ask the committee in its perusal of these plans to be certain that, before the plan is implemented, that you demand in detail the outline which I've attempted here to emphasize, and that you ask for specifics, and that you concentrate your attention on what is going on in the District, and that you certainly keep in mind that there is a vast area out there of professional expertise and, while we're saying that all of them ought to be brought into play in the consideration of what is going to be done, do not forget again the skills that particularly psychologists have at their hand. And if they are overlooked, there certainly will be, in my own opinion here, a tremen-

dous disservice which they have been rendering to patients in the hospital and to patients in the area now who will move into the community and who deserve morally, legally and otherwise a continuation of such patients.

I want to thank you for indulging my summary and the position here of D.C.P.A. and A.P.A. Thank you, Mr. Chairman.

[The prepared statement of Mr. Carr follows:]




TESTIMONY OF

WILLIAM E. CARR, Ph.D.

Washington, D.C.

on behalf of

THE DISTRICT OF COLUMBIA PSYCHOLOGICAL ASSOCIATION

and

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

U.S. HOUSE OF REPRESENTATIVES

Committee on the District of Columbia

Subcommittee on Fiscal Affairs and Health

on the subject of

THE DISTRICT'S PRELIMINARY PLAN TO IMPLEMENT

THE "SAINT ELIZABETHS HOSPITAL AND DISTRICT OF COLUMBIA

MENTAL HEALTH SERVICES ACT"

May 22, 1986

The Honorable Walter E. Fauntroy, Chair
1310 Longworth House Office Building

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Mr. Chairman and Members of the Subcommittee on Fiscal Affairs and Health, it is an honor and a pleasure to be invited here today to present testimony on the District of Columbia's preliminary plan to implement P.L. 98-621, the "Saint Elizabeths Hospital and District of Columbia Mental Health Services Act." I am Dr. William E. Carr, a consulting psychologist licensed to practice in the District. I am here today representing both the District of Columbia Psychological Association (DCPA) and the American Psychological Association (APA).

First, let me say that this Subcommittee accomplished what many thought to be an impossible task in effecting the passage of P.L. 98-621. That you should now assume the task of monitoring the development of the District's preliminary plan to implement that law is truly commendable. As practicing psychologists, the members of DCPA have been actively involved in responding to the problems of mental illness in the District since before the founding of the association in 1935. These problems stem from many roots including emotional deprivation, personality inadequacy, alcohol and drug abuse, domestic strife, prejudice, discrimination, and poverty. A comprehensive plan to treat the District's mentally ill is welcome.

Specifically, we commend the plan for its use of both national and local experts in its development. The plan's two stated priorities are laudable: to provide comprehensive mental health services to the chronically mentally ill and to children and youth. The goal to serve more of the mentally ill is responsive to one of the greatest needs of the District.

We have noted with approval the plan's organizing principle of geography.

The system must be organized geographically if the community is to have any meaningful participation in its administration. Citizens become involved in community affairs when they impact on their neighborhood. Geographic organization also maximizes ease of entry into the system. People have to know where to go for help, and it cannot be far away. Specialized treatment in specialized locations is useless if people never get into the system.

Some documents we have seen have made projections of the District's mental health needs based on studies of incomparable populations. We need to exercise care when estimating needs based on studies of other cities quite unlike ours. Some documents even used studies of rural populations to project the District's needs.

It is one thing to design a theoretically well-functioning system. It is quite another to implement it. With respect to the District's plan, we have serious concerns about whether viable implementation is indeed possible. Moreover, we have seen little detail specifying who is going to do what by when.

The system as it is outlined in the blueprint is vast, complex and difficult to comprehend in its entirety. We have two primary concerns regarding the scope of the plan. First, because it is difficult to comprehend, it will likely be difficult for the people served to work their way through it. Its vastness and complexity will work against delivering the services that are its primary task. Second, we fear that in such a vast and complex system, authority and accountability will be lost in the shuffle. We

all have experience in working with bureaucracies where no one is responsible and nothing gets done. We have the opportunity to minimize red tape in designing this system, and we seem not to have taken advantage of it.

One of our major concerns is with the continuity of care. We maintain that the plan must address in detail this element that research has demonstrated is the key to the successful outcome of mental health treatment. The plan's organizational structure can do violence to this element. In this regard, the 30-day hospitalization period as the definition of acute care can be expected to wreak havoc on the treatment of patients needing longer hospitalization.

The discontinuity will come at the time that the patient is beginning to develop some trust, confidence, and stability in his/her treatment environment. At this point, the individual is to be transferred to the long-term hospital where the process of developing familiarity, trust, and confidence will need to begin again. This will be compounded even further by the use of available beds in the many hospitals, both public and private, that the plan will utilize. The patient who needs several hospitalizations during the course of a year or two may be in a different hospital each time with a different team of health care providers. The supposed solution is the case manager, but one must not forget that the case manager does not provide direct care and may not be a part of the treatment setting.

On the other hand, the 30-day hospitalization criterion could provide an adverse incentive to prolong hospitalization for some patients inappropriately

as a means to qualify for further services. Hospitalization can be used to stabilize patients in shorter periods of time and the patients could then be referred to lower cost longer-term outpatient treatment programs. The need of the mentally disabled for stability, constancy and flexibility in their treatment environment for improvement to occur cannot be understated.

With respect to the private sector, the plan envisions the utilization of psychiatric units within the general hospital. The length of stay for psychiatric patients in general hospitals tends to be much shorter than the 30-day hospitalization criterion required by the plan. The plan must ensure the commitment of these units to the treatment of public sector patients and that the general hospital is willing to make the bed commitment that will be necessary in terms of length of stay. In other jurisdictions around the country, the track record of the private sector in treating public sector patients has been very poor.

We strongly support the notion of integrated, comprehensive care which is envisioned by the plan. This position demands that the needs of those with substance abuse problems, whether of alcohol or drugs, be addressed by the mental health system. Experience shows that most of these individuals have mental health problems, and that a significant percentage of individuals in the mental health system have problems of substance abuse. It makes no sense to artificially divide responsibility for these patients between two Commissions. This can only contribute to confusion and to patients in desperate need of services falling between the cracks. We understand that a task force is now considering this issue. We urge the placement of the

Alcohol and Drug Abuse Services Administration in the Commission of Mental Health to correct the existing fragmentation of services.

The west side of St. Elizabeths Hospital represents resources currently committed to mental health and most useful as mental health resources. We are concerned that if the west side of the Hospital is sold, mental health will lose more than the real estate value of the property. It will lose the opportunity to reuse them when and if the need arises. To sell the west side is to eliminate the future option of a geographically integrated resource. We prefer that the west side be used in such a way that it could be reconverted to a mental health facility at the discretion of the Mental Health Commission.

The organizational chart (p.95) of the system has located a variety of clinical support functions, including clinical discipline chiefs, in one component under the direction of a "Chief Medical Officer." The position is called a "Deputy for Clinical Services (DCS)" in the explanation of the chart (p.94) and in the description of the staff organization (p.267,268). The position description states that the Deputy for Clinical Services will be a board certified psychiatrist who will also act as a discipline director for psychiatry. There is no need for a discipline director of psychiatry also to be the director of the entire component. There is nothing in the clinical services position description that requires the expertise of a psychiatrist. Moreover, there is nothing in the training of a psychiatrist that uniquely qualifies him/her to direct the functions of record keeping, quality assurance, planning, program evaluation, billing, prevention, research, patient advocacy or inservice training (p.268,269). Furthermore, the Federal

Medicaid law was recently changed to delete the requirement that Medicaid clinics be under the administrative direction of a physician. Administration is now allowed to be performed by any qualified professional without regard to specific health profession.

We strongly recommend that the position description delete the requirement that the occupant be a psychiatrist. We further recommend that there be a discipline director for psychiatry along with the other discipline directors.

While we await the final proposal of staffing patterns, we have serious concerns about drafts which have been circulated. The role of psychologists does not appear to be clearly outlined nor given adequate visibility. Staffing for psychologists should recognize the unique combination of assessment, therapeutic, and organizational skills which psychologists bring to their work.

The virtual exclusion of psychologists from program director positions in the new system is puzzling. The drafters of the plan seem to ignore, whether through lack of knowledge or simple oversight, the special qualifications of psychologists to serve as program directors by virtue of their strong background and formal training in human behavior and organizational dynamics. The D.C. City Council established statutory provisions for expanded privileges for psychologists in providing mental health services to the citizens of the District of Columbia. It is important for the comprehensive mental health system to avail itself of this resource.

Senior level psychologist positions should be established within

components of the system (e.g., in each of the Adult Service Programs, in the Acute Hospital, in the Long-Term hospital, in the Consultation Team, in the Psychotherapy Unit, in Forensic Services, and in Child/Youth Services). Individuals in these DS-15 positions would be responsible for recruitment, supervision of unlicensed psychologists, provision of inservice training opportunities, and maintenance of the security and confidentiality of psychological test data and other psychology treatment records. The creation of such positions will also help to ensure the speedy, effective resolution of issues which transcend the boundaries of a single unit.

Adequate psychologist coverage needs to be assured for all patients in the system. There are many units, particularly in Forensic Services, which are without psychologists in the draft we reviewed. There are other units, including Intensive Day Treatment and the Acute Psychiatric Hospital-Admissions Unit which we feel are underserved in the proposal. The staffing of the Emergency Psychiatric Response Unit (EPRU) with two 24-hour a day psychiatrist positions and no psychologist positions flies in the face of The Health Care Facility and Agency Licensure Act of 1983, which provides statutory authority for qualified psychologists to admit patients to and discharge them from the mental health system. Also, having psychologists available in the EPRU will increase the likelihood of instituting behavioral and/or psychosocial interventions early in a crisis, which is likely to reduce the need for long-term hospitalization.

All service units should allow the flexible participation of all appropriate health professionals to encourage effective service delivery and

promote interdisciplinary communicatiopn regarding patient treatment needs. Moreover, it is inappropriate for a single discipline to be vested with statutory control over program direction or to be statutorally excluded from such positions. Service needs in the system are multi-disciplinary and can best be met by allowing flexibility in terms of professional roles. Granting program direction to only a single discipline tends to exacerbate professional rivalries and hamper efficient service provision.

We applaud the plan's inclusion of research and training as important components in the new system, and both of these activities require the involvement of psychologists in leadership roles. As the plan states, "Historically, public mental health systems without training programs have had great difficulty recruiting and retaining well-trained, culturally knowledgeable, linguistically competent professional staffs" (p. 255). In addition to increasing the desirability of the setting for competent professionals and thereby increasing the quality of patient care, experience at Saint Elizabeths shows that with fully accredited training programs significant numbers of graduates choose careers that involve working with patients in the public sector. These fully accredited training programs require continued support, whether from the District or from Federal funding. Psychologists in the Training Division at Saint Elizabeths have also been heavily involved in inservice training, which contributes to JCAH requirements for staff development. Inservice training must receive high priority in the new system, which places much of the direct patient care in the hands of paraprofessionals. Also, inservice training must meet the needs of professional staff for continuing education for licensure and/or

recertification, as is currently the case at Saint Elizabeths.

Thank you for the opportunity to testify on behalf of the District of Columbia Psychological Association and the American Psychological Association on the District's preliminary plan to implement P.L. 98-621. If I can be of any further assistance to the Subcommittee in its deliberations, please feel free to call upon me.

Mr. WILLIS. Well, we thank you, sir, and thank you Dr. Sharfstein for doing exactly what we would hope would be done by the monitoring process that we've spelled out in the legislation, and that is that you would anticipate certain problem areas in advance and, through testimony and through helping us monitor, give us some direction and that we can pass on to those who are putting it together.

Both of you raised questions and concerns about the continuation of research, appropriate research at St. Elizabeths. Both of you have noted in your testimony, both written and orally, the history of the fine work that's been done at various research centers. Would you expand a bit your concerns in that way, not going into too far detail; but do you see a time—have you heard something that this is going to be cut off? Is there a limitation on this?

Part of the legislation was based on the fact that there would be a continuation of research by the Federal Government at St. Elizabeths.

Mr. CARR. I am hopeful, sir, that this continuation already is a fait accompli, but like everyone else, as I've sat here this morning and listened to the ominous scenes that are now confronting us down the line insofar as finances are concerned, Gramm-Rudman and others, if there is an across-the-board kind of reduction of services, then I suppose logically we can assume that research and training will have to become victim to some of this thinking and some of these practicalities.

However, I feel that, if there is one area that should be exempt from any slashes, from any reductions, it's research and training. That is the basis upon which treatment, contemporary treatment, timely treatment, you see, here is realized, is manifest. And if we cut that off, then what happens is we stand still, and by standing still we engage in a retrogression. There are no new ideas. There are no new methods. There are no new—there's no new thinking. So research and training, as presently now being underwritten by Federal law in terms of appropriations, I think, should continue; and it should continue simply because, if we ever are going to get to the point where there are innovations in helping the mentally ill, then we realize we're going to need research and training to do it.

St. Elizabeths at the present time—the staff are doing an outstanding job in this respect, as I've attempted to point out here in the discussions groups which are being led by psychologists.

Mr. WILLIS. Dr. Sharfstein.

Dr. SHARFSTEIN. I agree very much with Dr. Carr's comments. You know, last year it's estimated that nationwide mental illness cost this country in direct or indirect costs around $90 billion.

Mr. WILLIS. That's $90 billion with a b?

Dr. SHARFSTEIN. $90 billion in both direct and indirect costs to the country for mental illness. The research investment in mental illness is woefully inadequate. St. Elizabeths, through the NIMH program, has had an outstanding record of pioneering research in many areas, including the neuroscience areas which could have very important breakthroughs for the No. 1 costly problem in mental illness, and that is schizophrenia.

It is estimated that in this country about $8 per schizophrenic patient is spent on research. Compare that to cancer patients where it's estimated about $500 per cancer patient is spent on research. To cut the research, which may be very easy to do in terms of some of the budget problems, would be very pennywise and pound foolish.

Mr. WILLIS. We would ask both of you as representatives of your organizations to encourage your members to actively lobby for a continuation of the research at St. Elizabeths, both at the Federal and the local level. I think, if you look carefully at the law, the committee made it very clear that we expected that to continue, and I think we would be hard pressed to find out that it was cut. But we're going to need a lot of assistance in this area. We carry some weight in some areas and a little weight in other areas, and mental health has not been a priority with this administration for 6 years, and there's no indication it's going to be in the future.

We need your help, and we need your association's help.

Mr. CARR. I might say, Mr. Chairman, if you'll indulge me just one moment here, that there is a difference between basic research and applied research.

Mr. WILLIS. That's right.

Mr. CARR. It appears, as I see it, that the Federal Government at the present time is more interested in the application of the findings of research than they are in the basic research. When any attention to the problem would indicate that unless we have basic research, which is now being carried on at numerous institutions, notably St. Elizabeths here, there will be none applied because there won't be anything, any knowledge there, you see, to any extent.

We've got to have that. And, certainly, we are going to attend to what you said here, and to point out the indispensability of basic research. Every penny spent in this area is spent well, and the returns on it here are just——

Mr. WILLIS. One of the concerns that has been raised with each one of the witnesses thus far, we will raise with you also, and that is the effect of the change, the transition or the development this program is having on key staff, both psychologists and psychiatrists.

It's important that we do not lose key staff, that they not become frustrated with the possibility of where they may or may not be. What do you hear and what do you see happening in your own associations among key people at St. Elizabeths? What's happening to them?

Dr. SHARFSTEIN. There is, in any time when you have a major change of transition, there will always be staff anxiety and you have to pay special attention to it. The main concern, I think, is that clinicians worry about their role in the new system and whether the implementation of the plan is going to fully take into account their concerns about patient care and their proper role.

I think that the next few years are really going to tell the tale. If indeed the plan is followed closely after close consultation with the clinicians, we will see an allaying of these anxieties and a capacity to retain the high quality clinical staff that's presently there.

As soon as there are capricious decisions, major cutbacks, compromises in the continuity of care or the quality of care, I think

you're going to see very rapidly an exodus of physicians. There is a shortage nationwide of psychiatrists, plenty of positions open at other places. People will begin to move in the context of a shortfall between the promise of the plan and the reality of its implementation.

Mr. CARR. I certainly endorse Dr. Sharfstein's remarks. And let's not kid ourselves. There is anxiety that I have observed. From time to time I get to visit my colleagues over at St. Elizabeths and other places. All of the work over the years which has been fait accompli, which has been manifest, now is under some kind of threat, as I have observed, and I guess, justifiably so.

People who are on the staffs of these institutions now cannot see down the road a lateral transfer of their services to here. I certainly have no doubt, and I am very trustful that the District of Columbia will in one fell swoop say we'll take the entire gamut of services that we have known at St. Elizabeths and transfer them to the District; but there's no guarantee of that at the present time.

There's no guarantee of—there's one thing that is certain and, as we've heard here this morning, that funds, you see, subsequent to 1987 when this plan is implemented here, are not going to be increased. Already we are in an area of the lack of funds necessary here to have a smooth implementation of the plan, and that is going to impact on everybody concerned.

So there is anxiety there. The professional careers of people here are at stake, and we need to face it, and we need to do something about it here in the attempt to prevent, as we say sometimes in my discipline, washing the baby down the drain with the bathwater.

Mr. WILLIS. Gentlemen, thank you very much. I would encourage you to watch very closely how we develop, and not only report to us but through your organizations to press the Federal Government. You have power and positions, because you represent professionals who vote, who are responsible, who know how to write letters to do that, to encourage your associations to track this and follow the system and follow the Federal Government's role in it as well as the city's role in it.

Thank you very much.

We will call our next panel of witnesses: Ms. Peggy Brown, legislative specialist, American Federation of State, County and Municipal Employees; Mr. Norman Rosenberg, director of Mental Health Law Project; and Dr. Leonard Stein, member, board of directors, the Dixon Implementation Plan. If you would come at this time, we'll take your testimony.

We will take you in the order that we have called you. Ms. Brown, we welcome you, appreciate your participating with us through the negotiations 2 years ago and your monitoring for AFSCME this legislation. You can present the testimony in summation or however you prefer.

**TESTIMONY OF PEGGY BROWN, LEGISLATIVE AFFAIRS SPECIALIST, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES.**

Ms. BROWN. I trust that my entire statement will be entered into the record. There are portions of it that I will leave out this morning, though.

I wanted to say good morning, and thank the committee for inviting AFSCME to these hearings. The American Federation of State, County and Municipal Employees is a labor union representing more than 1 million public employees nationwide, including 200,000 employees who care for the mentally ill and the mentally retarded.

AFSCME is also represented on the labor-management task force and the planning committee of the District of Columbia Mental Health System Reorganization Office.

My testimony today does reflect comments previously presented by AFSCME at the mental health system reorganization offices community hearings and comments before the D.C. City Council. As you know, AFSCME represents almost all of the nonprofessional staff at St. Elizabeths Hospital. Our members have provided quality services and patient care for the mentally ill at that institution.

As the functions, programs and resources of St. Elizabeths are transferred to the city, our primary concern is that the excellent standard of patient care continue, and that our members have the opportunity to provide those services.

When the law establishing—as the law establishes transfer provisions for employees of the hospital, we do have concerns, though, about the conditions of employment for those workers who accept a job with a private contractor. Such an employee should maintain benefits enjoyed while employed at St. Elizabeths now. This could be accomplished by having the city include minimum standards in all requests for proposals that are offered to implement the comprehensive mental health system.

We are also concerned about training and retraining former St. Elizabeths' workers for employment in the new system. We believe that an employment bank, which could be computerized, should be created so that employees' skills and qualifications can be matched with future jobs.

With respect to contracting out, we are concerned with how the city will operate a continuum of inpatient and outpatient mental health care, residential treatment, and support services through an appropriate balance of public and private resources, as mandated in the law. Under the preliminary plan, some services are private, and others are public. We believe that a balance should exist in individual components of the plan.

For example, it appears that all community based facilities will be run by private contractors. We believe that the city should also operate similar facilities so that you could provide a measure of performance.

Additionally, we believe that any former St. Elizabeths employee who decides not to accept employment in the new system should be entitled to his or her severance pay from the Federal Government.

Many of the concerns that I have mentioned today are addressed in an AFSCME Labor News Network produced film entitled, "Redeeming a Promise: Community Care for the Mentally Disabled." The film documents AFSCME's participation in the cities of Plymouth and Boston, MA, and Pueblo, CO. In those cities we assisted State authorities in developing comprehensive mental health services. "Redeeming A Promise * * *" is available for member and staff viewing, and I trust that the major themes of the film will be included as a part of the official hearing record.

As I mentioned earlier, AFSCME has had first-hand experience with the type of situation into which this city is about to embark. We are familiar with deinstitutionalization. We have warned decisionmakers about the homeless and about the horrible conditions in private nursing homes and community facilities.

At the same time, however, our members have continued to provide care in public institutions. We stand ready to work with the Congress, the city, and all involved to discuss these and other concerns in order to develop a good comprehensive system.

Again, I thank you for the opportunity to appear today and do hope that all of the members of the committee and all of the staff are able to view the AFSCME produced film that deals with this very subject.

Thank you.

Mr. WILLIS. Thank you.

[The prepared statement of Ms. Brown follows:]

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TESTIMONY

OF THE

AMERICAN FEDERATION OF STATE,
COUNTY AND MUNICIPAL EMPLOYEES

ON

P.L. 98-621, THE

"SAINT ELIZABETHS HOSPITAL AND
DISTRICT OF COLUMBIA
MENTAL HEALTH SERVICES ACT"

BEFORE THE

HOUSE DISTRICT OF COLUMBIA COMMITTEE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

MAY 22,1986

Mr. Chairman and distinguished members of the Subcommittee. I am of the American Federation of State, County and Municipal Employees (AFSCME), a labor union representing more than one million public employees nationwide, including over 200,000 workers who care for the mentally ill and the mentally retarded. AFSCME is represented on the Labor-Management Task Force and the Planning Committee of the District of Columbia Mental Health System Reorganization Office. I appreciate the opportunity to present testimony on the District's preliminary plan to implement Public Law 98-621, the "Saint Elizabeths Hospital and District of Columbia Mental Health Services Act". My testimony today reflects comments previously presented by AFSCME at the Mental Health System Reorganization Office's community hearings and before the District of Columbia City Council.

As you know, AFSCME represents almost all of the non-professional staff at St. Elizabeths Hospital. Our members have provided quality services and patient care for the mentally ill at that institution. As the functions, programs and resources of St. E's are transferred to the city, our primary concern is that the excellent standard of patient care continue and that our members have the opportunity to provide necessary services.

While Public Law 98-621 establishes transfer provisions for employees of the Hospital, we do have some concerns about the conditions of employment for those workers who accept a job with a private contractor. Such an employee should maintain certain

benefits enjoyed while employed at St. Elizabeths Hospital. This could be accomplished by having the city include minimum standards in all requests for proposals that are offered to implement the comprehensive mental health system.

AFSCME is also concerned about training and retraining former St. E's workers for employment in the new system. How will employees be matched with new jobs? We believe that an employment bank, which could be computerized, should be created and include a listing of all employees and their individual skills and qualifications. Referral to the "lists" would facilitate transferring of employees to other jobs and defining what types of retraining programs are necessary.

With respect to contracting-out, we are concerned with how the city will operate "a continuum of inpatient and outpatient mental health care, residential treatment, and support services through an appropriate balance of public and private resources" as mandated in the law. Under the preliminary plan, some services are private and others are public. But shouldn't a balance exist in individual components of the plan? For example, it appears that all community-based facilities will be run by private contractors. The city should also operate similar facilities to provide a "measure" of performance.

Additionally, AFSCME believes that any former St. Elizabeths' employee who decides not to accept employment in the new system should be entitled to his or her severence pay from the federal government.

As a final point, we were concerned, upon reading a newspaper article on the retirement system for new federal employees, that the "system would remove newly hired District of Columbia employees from the federal retirement program starting in October 1987". This provision contradicts provisions in Public Law 98-621. However, we have been assured by staff of the Post Office and Civil Service Committee that federal workers transferred to the District under Public Law 98-621 will not be affected by this particular provision.

Many of the concerns that I have mentioned are addressed in an AFSCME Labor News Network produced film entitled "Redeeming a Promise: Community Care for the Mentally Disabled". The film documents AFSCME's participation in the cities of Plymouth and Boston, Massachusetts and Pueblo, Colorado in developing comprehensive mental health services. "Redeeming a Promise..." is available for Member and staff viewing and I trust that the major themes will be included as part of the official hearing record.

As I mentioned earlier, AFSCME has had first-hand experience with the type of situation into which this city is about to embark. No one knows better than our members the realities of deinstitutionalization. We have raised some of the loudest voices warning decisionmakers about the homeless, and about horrible conditions in private nursing homes and community facilities. At the same time, our members have continued to

provide, in public institutions, quality care for the mentally ill and mentally retarded.

AFSCME stands ready to work with the Congress, the city and all involved to discuss these and other concerns in order to develop a good comprehensive mental health system.

Again, I appreciate the opportunity to appear before you today.

Mr. WILLIS. Dr. Stein.

**TESTIMONY OF LEONARD STEIN, M.D., MEMBER, BOARD OF DIRECTORS, DIXON IMPLEMENTATION MONITORING COMMITTEE**

Dr. STEIN. Thank you for the opportunity of appearing before you. My name is Leonard Stein. I'm a psychiatrist and professor of psychiatry at the University of Wisconsin Medical School. My special concern is the treatment of chronic psychiatric patients. I'm a medical director of the Dane County Mental Health Center in Madison, WI, which has been designated by the National Institutes of Mental Health as the National Training Resource for Community Support Programs for the chronically mentally ill.

For your further information, I have submitted as an attachment the summary of the description of Dane County's program from a recent report on care of the seriously mentally ill by Drs. E. Fuller Torrey and Sidney Wolfe, in which Wisconsin was ranked first in the Nation in the quality of services provided for persons with serious mental illness.

Before going on, I would like to just take a short opportunity to make some comments about some of Dr. Sharfstein's comments, since I am a member of the American Psychiatric Association and one of those 32,000, and also just a past member of that organization's committee on the chronic mental patient.

Just three brief areas. One was his mentioning about asylum and the need for having people in an institution for asylum purposes. Asylum really needs to be looked at as a function rather than as a place. And in the comprehensive system of community-based services we've developed in our community; we provide asylum to our chronic mentally ill persons, but that asylum is provided by support and services in the community to those patients.

Now there may be a very, very small number who require bricks and mortar, but in our experience that number is small, and asylum, I think, really must look—be looked at as a function and not a place.

His comments about doing a pilot study for the use of psychiatric units of general hospitals, I think, might be a good idea; but I have some concerns that, if one goes into those pilot studies for too long a period of time, it really is a delaying tactic.

There are a lot of people out there who don't want to use—that is, a lot of hospital administrators and attending physicians who don't want their psychiatric units of general hospitals used by this class of patient. I think that's really unconscionable.

I think we must start using our general hospitals' psychiatric units for these patients, and we need to just go on with that as quickly as we can.

The other is his mentioning that people who are behaviorally unacceptable by the community need to be segregated from the community. I'm sort of paraphrasing his words, but I was frankly shocked by that.

It's a measure—one measure of how free our society is, is the degree to which we are willing to live side by side with people who may behave idiosyncratically and perhaps unacceptably to us, but who do not break laws. If you break laws, that's a different matter,

but if one just behaves idiosyncratically and even unacceptably, we have an obligation as a member of a free society to accept those persons living among us.

I'd like to go on and talk now as a member of the Dixon committee. This committee was established in 1980 by the consent decree in *Dixon* v. *Harris* case in which the Federal court in 1975 ordered St. Elizabeths Hospital and the District of Columbia to jointly create a continuum of community based mental health care, so that mentally ill District residents who do not need hospitalization could be more appropriately served in the community.

This committee is composed of nationally recognized mental health experts, consumer and leaders in the Washington community. In its 6 years of existence this committee has had several site visits of the service programs, interviewed clients and staff, reviewed records, investigated complaints, and have filed public reports with recommendations about how the system might be changed.

Our monitoring has revealed consistent lack of compliance with the Dixon consent order and its plan for a system of community based mental health care. As a result, 3½ years ago the court, finding the conditions so lacking, imposed a moratorium on the transfer of patients from St. Elizabeths to the District.

That moratorium, which we reluctantly but necessarily support, is still in effect. At the same time, counsel for the Dixon plaintiff class asked the court to hold the District of Columbia in contempt. That motion has been held in abeyance until now, at our request, pending development of this plan.

We reiterate our strong support for the kind of unified community oriented mental health system envisioned by the Dixon litigation and mandated by the Congress in Public Law 98-621. We also commend Ms. Fleming and her staff for their extraordinary efforts in bringing together the multiple elements of the comprehensive plan to implement that legislation.

However, that plan has serious problems. Before describing those problems, however, I'd like to clarify the debate about the success or failure of the deinstitutionalization movement.

We have all heard a chorus of well intentioned claims that deinstitutionalization has failed, and that community treatment has not worked. This is simply not so. The deinstitutionalization movement has always been conceptualized as a two-step process: No. 1, the outplacement of patients from the hospital to the community; and No. 2, the coincident development of a comprehensive and integrated system of community-based care.

In every instance where both of those steps have been done, deinstitutionalization has been successful. Where step two was not done, patients have suffered. Thus, deinstitutionalization has not failed. The failure has been to complete the deinstitutionalization process by doing the second step, that is, developing a comprehensive and integrated system of community-based care.

However, in the District of Columbia a system to serve chronic mentally ill people in the community, a system agreed to by the District of Columbia in the Dixon consent order, has never been implemented. I offer you the latest of the Dixon committee's reports as an attachment. It documents immense gaps in the Dixon's

current administration of two especially critical programs, the crisis resolution and community outreach program.

In other reports and in earlier testimony before this committee, the Dixon committee has criticized the financing pattern that has promoted reliance on expensive and restrictive hospital services and discouraged the development of a community based system.

Public Law 98–621 itself helps resolve the underlying problem by combining the resources for the hospital and community care under a central administration.

I'd like to now make some comments about the mental health reorganization plan.

We are gratified that the District's reorganization plan takes the next important step, adopting the concept that the dollar must follow the patient. By charging the cost of hospitalization against the local service area's budget, this approach can encourage the use of less expensive and more effective community alternatives.

The plan for the new unified system then, with its shift from hospital-dominated to community-based services, could offer the first concrete hope for the District of Columbia residents who are chronic mentally ill, but we fear it may not hold out anything more than hope. We believe the plan is seriously flawed.

Let me point out three areas. One, it seriously underestimates the number of people who must be served. Two, it inexcusably fails to give priority to a large group of clients with the greatest and most immediate need for community-based services, and this group represents a large part of the Dixon class. And, three, to an unacceptable degree, it lacks specificity about the form, numbers, and timing of the services mentioned in the plan.

In the context of the Dixon committee's 6 years of unhappy experience with implementation of the Dixon plan by the District of Columbia, these deficiencies leave us pessimistic about translation of the plan into adequate services for the Dixon class.

To return to the aforementioned deficiencies in the reorganization plan: One, underestimation of people who must be served. The District projects the total active caseload for the new system to be about 5,000 patients. Using the District's own documents, we find the Dixon class alone numbers at least 6,000. And please keep in mind that the members of the Dixon class are the most seriously ill, who are people who are in the hospital or at risk for hospitalization and, thus, have an immediate need for appropriate mental health and support services.

No. 2, misplaced priorities. Although the plan gives lip service to strengthening services to an underserved group such as the homeless, its overall approach and budget and the additional information provided by the reorganization office make clear the intent to emphasize reorganization and staffing of existing outpatient programs over service to the homeless members of the Dixon class.

The reorganization office has budgeted only $3.2 million to serve 500 homeless mentally ill people through two existing community outreach branches and through contracts for mental health care in shelters. The Dixon committee finds this allocation of priorities, that is, serving people who are relatively healthy while those who are in desperate need and homeless—we find setting priorities that way indefensible.

A system that plans to serve only 5,000 clients when more than 6,000 are waiting must serve the neediest first. But the District is planning to serve first 2,000 clients who, while they have problems in living, are able to function on a day-to-day basis. And it is, at least initially, ignoring at least 1,500 serious mentally ill citizens who are homeless on this city's streets.

The plan does not say that nontraditional methods must be used to provide mental health services to homeless people where they are found, on the streets, in doorways, in vacant buildings, et cetera. However, a project—However, in projecting services for the 500 homeless people, it does not—it does plan to serve in the 1988—that is, it does plan to serve 500 of them in 1988. The city budgets only for the two existing community outreach branches and contracts—and contracts for services in shelters.

For the many members of the Dixon class who are on the streets today, a vague promise of eventual outreach is inadequate. Neglect, with its consequences of psychosis and multiple hospitalizations, is cruel and unacceptable. At least 10 more mobile outreach teams are needed, staffed with dedicated personnel who are specially trained to do this kind of work.

The need for staff training, which has been mentioned a number of times today, is indeed critical in serving persons with long-term mental illness in the community. The discussion of training in the reorganization plan is extremely vague. It does include a revealing list of training needs. The list runs from "transcultural understanding" to "functional and decisionmaking training for advisory boards and advocacy groups."

Although these are important, what shocks the Dixon committee is the plan makes no mention at all of any special training for outreach to work with homeless mentally ill people. We find this omission simply one more sign that the Dixon class may be as neglected in the new mental health system as it is today.

The third area is lack of specificity. The lack of specificity in the section on training is reflected throughout the plan. While its language is consistent with contemporary thinking in the design of mental health services, the plan has insufficient detail to give the Dixon committee any confidence that this language will be translated into a comprehensive and coordinated system of adequate services for chronic mentally ill people.

For example, the core services that a mental health system provides to clients with varying levels of need must be coordinated. Yet the District's plan does not define any coordinating mechanism. A suggested approach: The District's planning process for the new mental health system, while well-intentioned, is deficient. Despite the clear mandate in the Federal legislation that "the system implementation plan shall be in full compliance with the Federal consent decree in *Dixon* v. *Heckler*," the District has failed to plan properly in terms of both numbers of clients and services needed by the Dixon class.

We have made these concerns known to Ms. Fleming, and she has been most forthcoming in discussing the completed documents with us in meetings and by telephone. However, the mental health system reorganization office has consistently resisted our offers to help in the process of developing the reorganization plan.

Now we understand that every interest group is after Ms. Fleming to get on the committee to help her in reorganizing this plan. I've heard it from some of them earlier today. However, the Dixon committee is more than just another constituent organization. We've been empowered by the Federal court to monitor the Dixon consent decree. The legislation that was introduced by this committee mandates that Dixon be met.

Since 1980, our members have worked as a unit on that effort. We have experience and expertise in both planning for and implementation of mental health service systems. Our fuller involvement in the process of planning and implementing the District's new system could avoid court hearings and help ensure the development of a more complete and adequate service for chronic mentally ill District citizens.

We, therefore, suggest that the District committee in its comments and recommendations on the preliminary plan include a strong admonition to the District that it utilizes the professional competence and expertise of the Dixon Implementation Monitoring Committee at all stages of development of the final system implementation plan and during the transition period.

In conclusion, if you detect a note of urgency in my remarks, you're correct. We have tried to be helpful and nonadversarial as the reorganization effort has moved forward. We believe that the mental health system reorganization office needed to do its work in a climate of conciliation and collaboration, but as the days and weeks pass by and the time nears for the sign-off by the House District Committee and the city council, we are growing alarmed that this effort, the city's most important initiative for its disabled citizens, will perpetuate many of the deficiencies that have for so long plagued the delivery of mental health care in the District of Columbia.

The Congress and the mentally disabled citizens of this city are entitled to and must demand more.

This concludes my prepared testimony. Thank you, and I'll be glad to answer any questions.

Mr. WILLIS. Leonard, in all the years that I've known you, you've spoken with urgency. You've addressed this committee on numerous occasions. I recall our first interaction in the late seventies and early eighties over deinstitutionalization. I respect many of the things that you said.

[The prepared statement and attachments of Dr. Stein follow:]

STATEMENT

OF

LEONARD I. STEIN, M.D.

DIXON IMPLEMENTATION MONITORING COMMITTEE

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

OF THE

COMMITTEE ON THE DISTRICT OF COLUMBIA

U.S. HOUSE OF REPRESENTATIVES

PUBLIC HEARING ON THE

PRELIMINARY SYSTEM IMPLEMENTATION PLAN

FOR THE

COMPREHENSIVE MENTAL HEALTH CARE SYSTEM

MAY 22, 1986

Introduction

Mr. Chairman, members of the subcommittee, I am Leonard I. Stein, a psychiatrist and professor of psychiatry at the University of Wisconsin Medical School. My special concern is the treatment of chronic psychiatric patients. I was the co-developer of a program for the treatment of chronic psychiatric patients that won the American Psychiatric Association's Gold Medal Award in 1974. I am Medical Director of the Dane County Mental Health Center in Madison, Wisconsin, which has been designated by the National Institute of Mental Health as the National Training Resource for Community Support Programs for the chronically mentally ill. For your further information, I am pleased to submit as an attachment to this testimony the summary description of Dane County's program from the recent report on "Care of the Seriously Mentally Ill" by Drs. E. Fuller Torrey and Sidney M. Wolfe (Public Citizen Health Research Group, 1986).

The Dixon Committee

I appreciate the opportunity to testify today as a member of the Dixon Implementation Monitoring Committee. This committee was established in 1980 by the consent decree in Dixon v. Harris, a case originally decided in 1975 (Dixon v. Weinberger), which ordered St. Elizabeths Hospital and the District of Columbia jointly to create a continuum of adequate community-based mental health care to enable mentally ill District of Columbia residents who do not require hospitalization to be more appropriately served by day treatment, group homes, mobile outreach teams and other community-oriented programs and facilities.

The Dixon Committee is composed of nationally recognized mental health experts, along with consumers and leaders in the Washington community. In its six years of existence, the committee has conducted on-site evaluations of programs, interviewed clients and staff, reviewed records and investigated complaints. We have issued public reports with our findings and recommendations based on these activities and have provided detailed comments on proposed policies, procedures and budgets for mental health services in the nation's capital, including the preliminary system reorganization plan before you today.

Our monitoring has revealed a consistent lack of compliance with the Dixon consent order and its plan for a system of community-based mental health care. As a result, three and a half years ago the court imposed a moratorium on the transfer of further patients from St. Elizabeths to the District. That moratorium, which we reluctantly but necessarily support, is still in effect. At the same time, counsel for the Dixon plaintiff class asked the court to hold the District of Columbia in contempt. That motion has been held in abeyance until now at our request, pending the development of this plan.

We wish to reiterate our strong support for the kind of unified, community-oriented mental health system envisioned by the Dixon litigation and mandated by the Congress in Public Law 98-621. We would also like to commend Mrs. Fleming and the staff of the D.C. Mental Health System Reorganization Office for their extraordinary efforts in bringing together the multiple elements of the comprehensive plan to implement that legislation.

The Mental Health System Reorganization Plan

In recent years -- especially each winter, when the plight of chronically mentally ill people who are homeless becomes tragically visible -- we have all heard a chorus of well-intentioned claims that deinstitutionalization has failed, that community treatment has not worked. This is simply not so.

What the deinstitutionalization movement has failed to do -- here and in many other cities -- is to provide decent and appropriate care in the community to the kinds of patients once consigned to custodial institutions. I am here from Dane County, which does provide such services, to say that it can work, as long as you put into place a comprehensive system designed to do it.

But a system to serve chronically mentally ill people in the community, successful in Dane County and other places and agreed to by the District of Columbia in the Dixon v. Harris consent order, has never been implemented here. The studies and site visits by our committee have consistently shown tragic deficiencies in the most critical services for chronically mentally ill people, such as crisis resolution, outreach and case management. I offer you the latest of the Dixon Committee's reports as an attachment to this testimony; it documents immense gaps in the current administration of the District's crisis resolution and community outreach branches.

In other reports and in our testimony before this committee in support of the bill that is now Public Law 98-621, the Dixon Committee has criticized a financing pattern that has promoted

reliance on hospital services and discouraged the development of a community-based system. Public Law 98-621 itself resolves the underlying problem by combining the resources for hospital and community care under a central administration. We are gratified that the District's reorganization plan takes the next important step, adopting the concept that the dollar must follow the patient. By charging the cost of hospitalization against a local service area's budget, this approach can encourage the use of less expensive and more effective community alternatives.

The plan for the new unified system, then, with its shift from hospital-dominated to community-based services, could offer the first concrete hope for District of Columbia residents who are chronically mentally ill. But we fear it may not hold out anything more than hope.

Mental health care system planning is a familiar endeavor to most of the Dixon Committee's members. We have developed and implemented plans in our own jurisdictions. We have reviewed a series of plans developed in response to Dixon, including, of course, the Final Implementation Plan that is part of the 1980 consent order. And we have now had six years of unhappy experience with implementation of that plan by the District of Columbia. In the context of this accumulated experience, we are not confident that the preliminary reorganization plan as presented will be translated into adequate services for the Dixon class.

To be sure, the plan represents a generally acceptable framework of the continuum of services required by chronically mentally ill adults. But will an adequate system be fleshed out

on this skeleton? The plan does not contain enough information for us to tell.

We are especially concerned about three problems. First, we believe the plan underestimates the number of people who must be served. Second, it inexcusably fails to give priority to a large group of clients with the greatest and most immediate need for community-based services -- a group that constitutes a large part of the Dixon class. Third is an unacceptable lack of specificity about the form, range and timing of the services mentioned in the plan. Nothing we have seen convinces us that the same major deficiencies we have repeatedly identified in the District's current mental health care approach will be corrected or avoided after October 1, 1987.

1. Uncounted Clients

The preliminary plan enunciates a 10-year goal of serving 10,000 mentally ill clients. It then describes a current caseload of "7,000 outpatients with about 4,000 in active treatment at any given time" (p.101) and projects an increase in the active outpatient caseload to 4,500 patients by 1988. The estimated hospital population, after a series of outplacements to other facilities, will be under 500. The total is a projected active caseload for the new system of roughly 5,000 nonforensic patients.

We believe the Dixon class alone is at least 6,000. Defining its members as seriously mentally ill people who are hospitalized or at risk of hospitalization and using the city's own numbers (from the reorganization plan and in the Dixon

defendants' March 1986 semiannual report to the court), we count 1,200 current St. Elizabeths Hospital inpatients, most of whom should be moved to community-based facilities; 1,900 hospital outpatients; and 900 clients of the city's two community mental health centers (half of these centers' active caseload). The total is 4,000 chronically mentally ill adults currently in active treatment. If one adds to these 4,000 the reorganization office's own estimate of 2,000 homeless persons who are chronically mentally ill and who do not receive adequate care, */ the Dixon class comprises 6,000 people who have an immediate need for appropriate mental health and supportive services.

2. Misplaced Priorities

The discrepancy in numbers stems from the District's assignment of priorities for services under the reorganized system. Although the plan gives lip service to "strengthening services to underserved groups such as . . . the homeless," its overall approach and accompanying budget, with additional information provided by the reorganization office, make clear the intent to emphasize the reorganization and staffing of existing outpatient programs over services to these members of the Dixon

*/ The District's May 1986 proposal to the Robert Wood Johnson Foundation, in draft. A 1985 study by the Center for Applied Research and Urban Policy of the University of the District of Columbia counted the number of homeless persons in the city as 6,454. Other studies cited in the system reorganization plan indicate "that about one-quarter of the homeless men and one-third of the homeless women previously have been in a hospital for the mentally ill" (executive summary, p. 21). An even more conservative approach therefore would assume that one-quarter of 6,454, or 1,600, homeless people are entitled to services as Dixon class members.

plaintiff class. The reorganization office has budgeted only $3.2 million to serve 500 homeless mentally ill people, through two existing community outreach branches and through contracts for mental health care in shelters.

The Dixon Committee finds this allocation of priorities indefensible. A system that plans to serve only 4,500 clients when more than 6,000 are waiting must serve the neediest first. But the District is planning to serve first 2,000 clients who, while they have problems in living, are able to function on a day-to-day basis. And it is, at least initially, ignoring at least 1,500 seriously mentally ill citizens who are homeless on this city's streets. This is unconscionable!

The plan does properly mention basic elements of a mental health system that would be responsive to the needs of mentally ill people who are homeless. These are:

(1) active outreach to homeless people;

(2) interagency coordination and cooperation; and

(3) assistance to enable the operators of programs serving mentally ill homeless people to identify and help those who need mental health services.

The plan also correctly notes that nontraditional methods must be used to provide mental health services to homeless people where they are found -- on the streets, in doorways, in vacant buildings, under bridges and down dark alleys, as well as in shelters. However, in projecting services for the 500 homeless people it does plan to serve in fiscal 1988, the city budgets only for the two existing community outreach branches and for contract services in the shelters.

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A recent study*/ found that for every two homeless people observed on the city's streets or in shelters, five more are unseen. Many of these hidden homeless people are the severely mentally ill. Often they hide because they fear shelters even more than they fear freezing on the street. These very resistent patients are difficult to treat. They need sustained attention over months or even years, by professionals who visit them regularly and who develop the trusting relationship necessary for treatment. The two planned outreach units simply could not handle the job.

For the many members of the Dixon class who are on the streets today, a vague promise of eventual outreach is inadequate. Neglect, with the consequences of return of psychosis and multiple hosptializations is cruel and unacceptable. At least 10 more mobile outreach teams are needed, staffed with dedicated personnel who are specially trained.

The need for staff training is indeed critical in serving homeless people. The plan proposes a separate Office of Training and we understand that a special request is made for continued support of a major training program now sponsored by St. Elizabeths Hospital. One-quarter of the requested funds or $1.5 million, would be for in-service training. The committee agrees that in-service training is particularly important, in light of the dramatic shift for much of the existing staff from hospital-based responsibilities to a community orientation.

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*/ The UDC count, mentioned in the previous note.

The discussion of training in the reorganization plan is extremely vague, but it does include a revealing list of training needs (p. 259). This list runs from "transcultural understanding" to "functional and decision-making training for advisory boards and advocacy groups." It makes no mention at all of any training in outreach techniques or specialized work with seriously mentally ill people. To the Dixon Committee, this omission is simply one more sign that the Dixon class will be seriously neglected by the new mental health system as it is today by what one can call the city's non-system.

3. Lack of Specificity

The lack of detail in the section on training is reflected throughout the plan. While its language is consistent with contemporary thinking in the design of mental health services, the plan has insufficient detail to give the Dixon Committee any confidence that this language will be translated into a comprehensive and coordinated system of adequate services for chronically mentally ill people.

For example, the core services that a mental health system provides to clients with varying levels of need must be coordinated. Yet the District's plan does not define any coordinating mechanism.

A Suggested Approach

Mr. Chairman, the District's planning process for the new mental health system, while well-intentioned, is deficient. Despite the clear mandate in the federal legislation that "the

system implementation plan shall be in full compliance with the Federal court consent decree in Dixon v. Heckler" (Sec 4(c)), the District has failed to plan properly in terms of both numbers of clients and services needed by the Dixon class.

We have made these concerns known to Mrs. Fleming, and she has been most forthcoming in discussing the completed documents with us, in meetings and over the telephone. However, this has come too late in the process for us to make constructive objections to planning assumptions and seek restructuring of services. We suggest that the District Committee, in its comments and recommendations on the preliminary plan, include a strong admonition to the District that it utilize the professional competence and expertise of the Dixon Implementation Monitoring Committee at all stages of development of the final system implementation plan and during the transition period.

The Dixon Committee is more than just another constituent organization. We have been empowered by the federal court to monitor the Dixon consent decree. Since 1980, our members have worked as a unit on that effort. We have experience and expertise in both planning for and implementation of mental health service systems. As we have suggested to the reorganization office and the District of Columbia Council, the Dixon class offers a model for the creation of a successful system. The Dixon Committee is ready and willing to assist in the development of such a model to serve these most difficult clients. In addition, our fuller involvement in the process of planning and implementing the District's new system could avoid court hearings and help ensure the development of more complete

and adequate services for chronically mentally ill District citizens.

Conclusion

If you detect a note of urgency in my remarks, Mr. Chairman, you are correct. We have tried to be helpful and nonadversarial as the reorganization effort has moved forward. We believed that the Mental Health System Reorganization Office needed to do its work in a climate of concilation and collaboration. But as the days and weeks pass by and the time nears for sign-off by the House District Committee and the City Council, we are becoming alarmed that this effort -- the city's most important initiative for its disabled citizens -- will perpetuate many of the deficiencies that have plagued the delivery of mental health care in the District for so long. The Congress and the mentally disabled citizens of this city are entitled to -- and must demand -- more.

# Care of the SERIOUSLY MENTALLY ILL

## A RATING OF STATE PROGRAMS

E. Fuller Torrey, M.D. &
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**Public Citizen Health Research Group**

**D. Comprehensive services: Dane County, Wisconsin**

Dane County, Wisconsin, has acquired a national reputation for excellence for its services to the seriously mentally ill. The keynote of these services is their comprehensiveness, with a full range of services available to meet the needs of approximately 1100 seriously mentally ill adults in the county of 323,000 persons. The use of inpatient hospitalization has been reduced dramatically from 10,100 hospital days per year in 1977, to 2,600 in 1985. The seriously mentally ill are maintained in the community with medications and "assertive case management," which takes mental health professionals onto the streets where they actively seek out patients who have not come in for scheduled appointments. At the same time the housing and vocational needs of these persons are addressed through contracts between the Dane County Unified Services Board and the YMCA (which runs small housing units) and Goodwill Industries (which provides job training). The case management of approximately 10 percent of the seriously mentally ill is done by an experimental program funded by the National Institute of Mental Health (Program of Assertive Community Treatment or PACT) and the others by the CMHC.

It is interesting to speculate why a county in central Wisconsin has moved so far in front of other counties in the United States in a program for the seriously mentally ill. Wisconsin's long history of decentralizing responsibility for services to counties is one element, and this was strengthened in 1974 when the counties were given full responsibility for both inpatient and outpatient funds for seriously mentally ill county residents. Thus, a county could spend its money hospitalizing such individuals, or utilize the same money to provide services in the community which is what Dane County did. The PACT program which began in 1972 has also been important by providing a nucleus of well-trained and committed mental health professionals. Such individuals attract others who are similar so that now the county has an outstanding group of mental health professionals dedicated to public service. Dane County was also the origin of one of the earliest AMI family consumer groups in 1977, and they have acted as an impetus for the development of services. Finally, the general intellectual milieu of Dane County, which includes the city of Madison and the University of Wisconsin, is innovative and encouraging of experimental programs.

The Dane County program is still far from perfect. There are waiting lists for many services, some families complain that hospitalization is not used enough, and some seriously mentally ill persons still fall between the cracks. But it is cost-effective and significantly more comprehensive than any other program in the United States. Further information on the program is available from Dr. David LeCount, Mental Health Coordinator, Dane County Unified Services Board, 1206 Northport Drive,

Madison, WI, 53704. The program has been described in numerous publications including the following: three articles by L.I. Stein, M.A. Test, and B.A. Weisbrod in *Archives of General Psychiatry*, 37:392-412, 1980; L.I. Stein and M.A. Test (eds), "The Training in Community Living Model: A Decade of Experience", (San Francisco: Jossey-Bass, 1985).

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## SITE VISIT AND FOLLOW-UP VISITS TO THE CRISIS RESOLUTION BRANCH AND COMMUNITY OUTREACH BRANCHES

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Edited by Lee A. Carty

March 13, 1986

## INTRODUCTION

In July 1982, at the court's direction, a site-visit team conducted an evaluation of the District's mental health service system. As reported to the court on August 12, 1982, serious deficiencies in both the scope and quality of services were found, prompting the Dixon plaintiffs to file a motion for contempt and appointment of a special master.

In April 1983, the Dixon Implementation Monitoring Committee submitted a follow-up report on continued deficiencies in client care at South Community Mental Health Center. Shortly thereafter the parties in the Dixon case began informal discussions seeking specific commitments by the District to improve the components of the system most crucial to meeting the needs of chronically mentally ill members of the Dixon plaintiff class. The parties agreed that initial efforts would focus on outreach and crisis services through the development of an upgraded crisis resolution branch (CRB) and two mobile treatment units or community outreach branches (COBs).

The District agreed to have these three units operational within a year. Additional resources were to be allocated and 45 additional staff were to be recruited by the District and trained at the Dane County Mental Health Center in Madison, Wisconsin, a program designated by the National Institute of Mental Health as a training center for professionals working with chronic patients. It was also agreed that the Dixon Committee and the Dane County program managers would make follow-up site visits and provide ongoing consultation until the upgraded CRB and the two COBs became fully operational.

## I. SITE-VISIT PROCEDURES

On March 12 and 13, 1985, eleven mental health professionals (members of the Dixon Implementation Monitoring Committee, expert consultants and social work interns) conducted a site visit at three locations: (a) the Crisis Resolution Branch (CRB); (b) the North Center Community Outreach Branch (NCOB); and (c) the South Center Community Outreach Branch (SCOB). Protocols for the evaluation were provided to the administrator of the Mental Health Services Administration (MHSA) prior to the visit.

The site visitors were divided into four teams. Team I consisted of Bernard Cesnik, M.S.W., Dane County Mental Health Center, Jean Blanchard, Crossing Place and Leonard Stein, M.D., a Dixon Committee representative. On March 12 and 13, this group visited the Crisis Resolution Branch. They analyzed the population served and the unit's operation.

Team II evaluated the North Center Community Outreach Branch on March 12 and the South Center Community Outreach Branch on March 13. This group consisted of Dorothy Hall-Richardson, R.N., and Ronald J. Diamond, M.D. both of the Dane County Mental Health Center Mobile Community Treatment Unit (DCMCT). Their visit focused on the delivery of services to clients at NCOB and on unit management at SCOB.

Team III, comprising Dorothy Sharpe and Charles Morgan of the Dixon Committee, conducted interviews with the following people: Robert N. Williams, Chief, Adult Services, North Community Mental Health Center (NCMHC); Gerry Bentley, M.S., Program Manager, NCOB; William Magwood, R.N., NCOB; Conrad Hicks, Acting Chief, South Community Mental Health Center (SCMHC);

Georgia Gross-Butler, Chief, Adult Services, SCMHC; Flora Wolfe, Program Manager, SCOB; Joanne Mandisadza, Mental Health Specialist, SCOB; LaVerte Mathis, M.S.W., Acting Manager, CRB; and Yvonne Stearns, Day Shift Supervisor, CRB. These interviews, augmented by review of the relevant program documents, were designed to evaluate the relationship between the Dixon standards and the COBs' and CRB's management systems.

Leonard Higgs, coordinator of the Dixon Committee, assisted the three teams and coordinated Team IV, composed of Angela McCann, Kimberley Douglass and Carrie Brown, social work interns. Team IV reviewed records of 58 client files (40 from the CRB and 18 from the COBs).

Because the MHSA administrator had informed the Dixon Committee that additional physicians would join these units by July 1, 1985, the committee made a return visit in October. Leonard Higgs and Thomas Clark, a social work intern, made follow-up visits to SCOB on October 2, 3 and 4, to the CRB on October 3, 4 and 7, and to NCOB on October 9 and 10. During these visits, 49 client records were reviewed. Client-contact logs were also inspected and staff interviews conducted. On January 9 and 10, 1986, Leonard Higgs made additional follow-up phone calls to SCOB and CRB.

The following sections of this report discuss findings of the site-visit teams and additional information obtained through follow-up visits and calls in October 1985, January 1986 and March 1986, and the extent to which these findings indicate compliance or lack of compliance with the Final Implementation Plan and Program Standards in Dixon v. Bowen and Barry.

We would like to thank the staff of MHSA and the CMHCs for their cooperation and their participation in interviews and for providing the data, logs and records that form the basis of this report.

## II. CRISIS RESOLUTION BRANCH

The Crisis Resolution Branch (CRB) is located at 1905 E Street, S.E. In October 1984 responsibility for it was transferred from the MHSA to the District of Columbia's Commission of Public Health (CPH). In March 1985 it had a staff of 30, augmented in July by one part-time physician. The CRB serves an average of 192 clients a month. Defendants' Semi-Annual Progress Report, 4/1/85-9/30/85.

As stated in the Dixon program standards,

> The goal of crisis intervention is the restoration as promptly as possible of the equilibrium which existed prior to the acute emotional crisis experienced by the patient/client (together with its physical and social concomitants). Associated with this goal are three objectives: the immediate reduction of acute emotional distress and its physical and social manifestations, and assurance of the safety of the patient/client and of others; minimal disruption of the patient/client by resolution of crisis in the least restrictive setting appropriate to the nature of the crisis. Standards, p. 36.

The standards also identify four elements crucial for an effective crisis intervention service: (1) 24-hour telephone counseling, (2) 24-hour walk-in service, (3) 24-hour outreach service, and (4) temporary residential service. Referral to these services may be made by (a) the individual experiencing the crisis, (b) a family member, or (c) any concerned other. Standards, pp. 37-38.

### A. IMPROVEMENTS AT THE CRB

The site-visit team found improvements in three areas.

#### 1. Staff Outreach

The number of home visits has increased. In 1982 use of this important clinical tool was negligible -- nine visits in a

month, for example -- (Site-Visit Report, pp. 19 and 35) and in 1983 (Dixon Committee Report on Client Care at South Community Mental Health Center, April 5, 1983, hereinafter "1983 Client Care Report," pp. 34-35). In 1985, CRB staff made an average 18 visits each month.

2. Physical Plant

The CRB offices are much improved from the stark institutional setting observed during the 1982 site visit. The offices have been painted and new carpeting has been laid, providing a more pleasant work situation for staff and a more humane environment for clients.

3. Unit Leadership

When the unit was transferred from MHSA's jurisdiction to CPH's, in October 1984, the manager was removed and an acting manager named. The position is still filled on an acting basis. The acting manager of the CRB is seen by the staff as a supportive leader. In October 1984, he began meeting with other community service providers in order to clarify the role of the CRB and to develop positive working relationships with them.

Despite these strengths, however, serious deficiencies continue to hamper efforts by CRB staff to fulfill the unit's mission of stabilizing clients without resort to hospitalization.

B. PROBLEMS IN PROGRAM ADMINISTRATION

Program administrators "should promote the effective operation" of units for which they are responsible "in a manner which is consistent with the organization's stated goals and

objectives." Standards, p. 4. The team found that the CRB administrators fail in the most fundamental way to comply with this standard, beginning with their failure to articulate any long- or short-range goals or objectives.

1. Mission Statement

The Dixon standards require:

> A statement of the organization's [CPH's or MHSA's] purpose or mission, including long-range goals and their relationship to what is known about community service needs. In addition, annual objectives consistent with long-range goals should be formulated for each subunit....Standards, p. 4.

During the March 1985 site visit to the CRB, the team received a mission statement (attached) written by the acting director. The statement did not include the annual objectives that the standards require to "be formulated in observable or measurable terms." Id. The absence of these fundamental definitions has a negative effect on every aspect of the program's administration. Further, it militates against effective service delivery by preventing meaningful evaluation and thus impeding improvement of crisis services.

2. Manual of Policies and Procedures

> A manual of policies and procedures which are internally consistent will be available. This shall be reviewed and updated annually, be available to all staff, and new staff should be oriented to all policies and procedures relevant to their positions. Standards, p. 5.

During the March 1985 site visit, the team was told that a new policy manual (attached) was being developed for the CMHCs. A year later, according to information provided by telephone on March 3, 1986, the manual is still not approved.

In addition, the acting manager of the CRB has developed informal policies (attached) governing referrals to the Adult Outpatient Department of the CMHC and setting forth staff responsibilities for telephone and walk-in clients. However, these informal policies were developed without consultation with staff of the numerous other services with which CRB interrelates.

3. Program Evaluation

The Dixon standards require "documented program evaluation activities which are adequate to determine whether the activities of service units meet current program goals and objectives." Standards, p. 5. The standards further require that the process of service delivery be evaluated, "including the accessibility, continuity, efficiency, and acceptability to clients of current service delivery practices." Id.

Although the CRB maintains records of the number and types of services rendered, these statistics by themselves are not useful in determining whether the unit is fulfilling its mission. Without a statement of measurable objectives, such questions cannot be answered.

Interviews with the acting director and other CRB staff did not reveal any formal evaluation mechanism to examine the unit's effectiveness or to guide staff in improving services.

4. Staffing

The job descriptions for CRB personnel restate the broad program goals and underscore the need for well-trained, high-quality staff:

> The primary purpose of the unit is to assist persons displaying symptoms of mental illness in resolving their emotional crises without resorting to psychiatric hospitalization unless absolutely necessary. The unit staff is frequently required to make rapid, sound decisions in alleviating life or death situations. Upon notification of a possible crisis, one or more professional staff members along with paraprofessional employees address the problem in an attempt to reach possible resolution follow-up.

The standards for personnel administration and staff development require an organizational structure "which maximizes the contribution of personnel and insures that staff are competent in the performance of their designated functions." Standards, p. 6. Among policies required are those for:

1. Staffing Needs. There should be documentation of the system's overall staffing needs based on anticipated workload, and description of methods for meeting these needs.

2. Staff Recruitment and Hiring. Staff shall be recruited and hired who are sensitive to patients'/clients' cultural, social and economic values and beliefs; who are sensitive to their personal preferences and their needs; and who are committed to their right to be treated in the least restrictive most normal setting possible and to helping them achieve and maintain the highest level of functioning and maximum independence possible. Every effort will be made to screen out those applicants who would fail to work in the patients'/clients' best interests.

Id.

During the March site visit, every staff member interviewed stated that lack of physician coverage was a major obstacle to successful operation of the CRB. Subsequently, full physician coverage was achieved by the addition in July of one part-time physician. However, because the physicians at the CRB are under contract instead of being hired as regular employees, they are not covered by the District's malpractice insurance. For this

reason, the acting manager of the CRB reported, two of the physicians refuse to make home visits. A third doctor avoids making home visits that he feels might subject him to a malpractice claim. The acting manager said that he had reported this situation to the Commission of Public Health but that no action has been taken.

As of January 1986, the CRB remained hampered in the fulfillment of its charge by other staffing problems. During the March 1985 visit, in addition to having a shortage of the physicians, the CRB was short-staffed by four mental health counselors, one mental health specialist and two psychiatric nurses. A year later, as of March 3, 1986, those seven vacancies have not been filled. In fact, two other mental health specialists and one contract nurse have departed the unit, leaving only three psychiatric nurses to cover all three daily shifts.

The Dixon standards suggest an interdisciplinary approach to crisis intervention:

> All crisis workers should have special training which assures their competence in the techniques and practice of crisis intervention, as well as familiarity with the range of existing community mental health, medical, and social services to which patients/clients may be referred. Medical and psychiatric assistance on a consultation basis should be immediately available, when indicated, to all types of crisis workers. If the crisis worker is not familiar with the patient/client or his or her individual treatment or community services plan, the crisis worker should contact immediately the appropriate treatment person and bring him or her into the crisis resolution process, particularly if the crisis is of a serious nature and if hospitalization is being considered. Standards, pp. 38-39.

In addition, the standards point out that "[c]risis intervention services may be provided by psychiatrists, psychologists, social workers, psychiatric nurses, and paraprofessionals." Standards, p. 39. Yet, even though an in-house organization chart reflects this multidisciplinary approach, CRB physicians often make decisions without consulting other staff.

An interactive and multidisciplinary team approach is essential for adequate evaluation, treatment and resolution of crises. A crisis cannot be viewed as an isolated episode; the physical and social concomitants must also be taken into account. Standards, p. 36.

In addition, if any member of the crisis team lacks "appropriate training in crisis intervention methods," the District is required to provide "additional formal training or supervised on-the-job experience...to carry out crisis services." Standards, pp. 39-40. The acting CRB manager acknowledged that no ongoing inservice training exists. The persistence of this deficiency (1982 Site Visit Report, p. 17) is evidence of a serious administrative barrier to the delivery of quality services to Dixon clients.

Dixon standards for crisis resolution require that "services should be consistent with the patient's/client's background and language." Standards, p. 37. Further, the staff-recruitment standard states: "As much as possible, the distribution of staff shall reflect sensitivity of staff to ethnic and language backgrounds of individuals in the service area." Standards, p. 6. Yet an entry from the CRB phone log of September 22 reads that assistance was not provided because "no Spanish speaking

staff at CRB." Such a history indicates a lack of effort by MHSA and CPH administrators to comply with these standards.

A further administrative problem -- one that limits the quality of service by reducing staff morale -- is staff tenure. Staff were hired on three-year temporary appointments, which end in 1987. With the transfer of St. Elizabeths Hospital and its staff to the District of Columbia, CRB staff are understandably concerned about their job security. When these CRB and COB employees were hired, the Dixon Committee expressed concerns about the temporary status. We were assured, however, that such temporary appointments were standard operating procedure and that these positions would eventually be converted to permanent status. They have not yet been so converted. The Dixon Committee is concerned that in addition to its continuing detrimental effect on staff morale, insecurity about tenure may mean further loss of trained personnel to agencies that can assure job security.

6. Budget

Under the standards for fiscal administration and budget, the budget must specify:

> the annual needs of each unit and of the organization as a whole for space, staffing and capital necessary to achieve stated goals and objectives. The budget will include funds for the evaluation of service utilization and effectiveness, and for staff evaluation and development. Standards, p. 8.

The acting manager stated that no budget exists specifically addressing the needs of the crisis resolution unit, as required by this standard. The acting manager and the South Center

director both confirmed that annual budget requests and allocations are made for the entire center; there is no line item for the CRB or for any other center units. It follows that the District's fiscal management system does not identify funds for evaluation of service utilization and effectiveness, as required by this Dixon standard.

Without the capacity to allocate funds for staff, equipment, and needed resources, how can the CRB operate efficiently? The current scheme precludes reallocation of resources to correct deficiencies and improve service delivery.

C. Service Delivery

The administrative problems listed above illustrate ineffectual or nonexistent planning. The failure of the CRB administration to state goals and measurable objectives and to view available resources in the context of these goals and objectives militates against adequate service delivery to clients. The result is illustrated by several cases from the CRB records, summarized below.

1. Home Visits

The CRB has no clear policies or guidelines for when staff should make a home visit. Currently, the decision is made by staff consensus. When the CRB staff member who receives a crisis call decides that a home visit is warranted, available staff are convened to evaluate the situation. This process is useful in many contexts, but as used at the CRB it lacks consistency and often results in delay and confusion.

Home visits for the month of September were examined to assess the result of this practice. Most had been scheduled at least two hours after the original call -- some as long as three days later. Often the client had left the site of the crisis before CRB staff arrived, or the nature of the crisis had changed and emergency commitment had become necessary. The following case from the CRB telephone log highlights the problem.

> A 22-year-old client with a history of hospitalizations was last discharged on July 30, 1985. He also had a history of drug abuse.
>
> The client's mother called CRB on September 10, 1985, reporting that her son had been exhibiting aggressive behavior for the last month -- breaking windows, slapping his sisters and brothers for no apparent reason, ripping the phone off the wall. The mother had been scheduled to appear before the Mental Health Commission on September 5 to have her son committed, but the appointment had been rescheduled for October 1.
>
> CRB staff decided that a home visit should be made at 11:30 the following morning, September 11, and told the mother they would call before leaving. When they called, the phone had been disconnected. At 1:45 pm the mother called CRB to say that the client had ripped the phone off the wall. She left a number where she could be reached. While the mother was talking to CRB, the client walked out. The mother said she would call again when her son returned. The home visit was rescheduled for September 13.
>
> On September 13, CRB and COB staff visited the home. The client had a knife and was assaultive to his mother, the staff and police. Windows and furniture had been broken and the phone was again ripped out. The client was committed to St. Elizabeths Hospital. There is no record of follow-up.

The decision to make a home visit is too often guided by the availability of staff and transportation instead of by clients' needs. The Dixon standards for outreach require that "transportation must be immediately available to crisis outreach staff." Standards, p. 40, emphasis added. While one of the two ambulances assigned to the CRB is equipped with two-way

communication, CRB has no base radio to communicate with the ambulance. The one car assigned to the CRB has no phone. As a result, if CRB staff are already responding to one call when another comes in, home visits -- however urgent -- must be postponed until these staff members return. The following excerpt from the CRB phone log of September 26, illustrates:

> This individual is assaultive, cuts the furniture, urinates in the kitchen. Action: Home visit postponed until better staff coverage.

2. Stabilizing Clients

The Dixon standards require crisis staff to take "immediate action to facilitate stabilization," with "minimal disruption to the patient/client by resolution of the crisis in the least restrictive setting appropriate to the nature of the crisis." Standards, p. 36. The case example below shows how failure by the CRB to take appropriate action can lead to a great deal of disruption for the client without facilitating stabilization.

> On June 6, 1985, a 32-year-old St. Elizabeth Hospital outpatient was referred to the CRB from the House of Ruth Shelter for Homeless Women because she was threatening violence to other residents. CRB tranquilized and released her because she had an appointment at SEH the next day. However, on June 7, at the request of shelter staff, the client was returned to CRB by the police, who said the client would not be allowed to return to the shelter. The CRB physician refused to provide further assessment and treatment and instructed the officers to return the client to the House of Ruth. If the shelter wouldn't accept the client, the doctor told them, they could take her to the CCNV shelter on 2nd Street.
>
> The client was next seen at CRB on September 5, when she was again tranquilized and released. On September 15, CRB transferred her to St. Elizabeths Hospital under emergency commitment.
>
> CRB has no record of any communication with the hospital or of any subsequent follow-up.

3. Continuity of Care

The case cited above is typical of CRB's pattern of service delivery: Clients are seen, then released with an appointment slip and no further support. This pattern was documented in the 1982 Site-Visit Report, pp. 33-34, as a significant failure in the effort to provide the continuity of care that is one of the basic concepts of the Dixon Final Implementation Plan. Plan, p. 2. The March 1985 site-visit team reviewed 12 randomly selected records of CRB clients referred to North and South CMHCs for follow-up services. Six did not keep their scheduled appointments. CRB did not follow up any of the cases.

Both the 1982 and 1983 reports negatively characterized the existing crisis resolution unit as only a "traffic directing" unit -- a service that does one-time evaluations and then directs the crisis to another resource. 1982 Site-Visit Report, p. 16; 1983 Client Care Report, p. 34. As illustrated in the preceding case example and others cited throughout this report, the 1985 site visit and subsequent investigation show no significant change. The following case is especially poignant for its lack of follow-up in the absence of any appropriate referral.

> Staff at a community residence facility called CRB on September 9 about a client who was "withdrawn and catatonic." The client and his mother were taken to CRB in an ambulance. The CRF doctor also sent the client's history.
>
> After the client arrived at the CRB, the physician on duty decided that he should have gone directly to St. Elizabeths Hospital. The ambulance drivers waited 40 minutes while the doctor tried to contact SEH. At that point, the ambulance drivers could wait no longer and returned the client to his community residence facility.
>
> There is no record of CRB follow-up.

4. Averting Hospitalization

CRB staff are expected to evaluate a client's situation and try to resolve the crisis -- first, in the place where it occurs; second, if necessary, in a temporary residential crisis facility; third, as a last resort, in a hospital. Standards, p. 36. The 1982 site-visit team found that crisis resolution staff did not act to avert hospitalizations. 1982 Site-Visit Report, pp. 17 and 23. The 1983 client care survey found no improvement. 1983 Client Care Report, p. 35. The 1985 team has come to the same conclusion. Of the 40 clients whose records were reviewed during the March 1985 site visit, nine (23%) were referred to St. Elizabeths Hospital; in the October follow-up visit, records were reviewed of 23 clients, seven of whom (32%) were referred to SEH. During September, 71 (29%) of the 249 walk-in clients seen by CRB were referred to SEH.

Sadly, as the following case demonstrates, hospitalization is sometimes ordered even when CRB staff believe it is not necessary.

> On September 11, CRB received a call from Adult Protective Services (APS) about a 59-year-old blind, diabetic woman, a double amputee. Her husband had recently been hospitalized with terminal cancer. The APS worker was at the client's apartment and reported that the client was in the same condition as when CRB had referred her to St. Elizabeths Hospital in late July. She was not eating or taking her medication and resisted any assistance. The APS worker asked that CRB staff make a home visit to help readmit the client. The CRB physician commented on the apparent absence of proper discharge planning and suggested the APS worker call the doctor who had discharged the client from SEH on August 2.
>
> The next day, the CRB team met the APS worker and the client's niece at the client's home. The niece had the keys but the door was chained and the client asked everyone to leave. The niece reported that the client had not eaten or taken any insulin for nearly a week. The police were

called; they unscrewed the chain and entered the apartment. The client was "upset" about the forced entry and would not talk to the CRB team. After conversing with the APS worker and the police, the CRB team decided to take the client to D.C. General Hospital for a medical evaluation. The client was taken to D.C. General but refused treatment.

A September 12 progress note describes the client as "paranoid and slightly delusional" and having "poor judgment and insight; appropriate affect, no ambivalence," but as undergoing a "social service emergency" rather than a physical crisis. She was "not suicidal/homicidal; calm; unable to care for herself so danger to herself" the note stated, so "APS...will place client in custodial environment or with a relative."

A progress note written the next day shows what happened: "negative behavior continues; refused medical exam and food; failed attempts to involve family; APS maintained [client's] problem is mental illness and were uncooperative; transport to SEH."

CRB had no record of follow-up in this case. The poor discharge planning identified by the CRB doctor is part of the problem, but blaming the hospital does not help the client. Having responded to this same client less than two months earlier, all of the agencies involved (APS, CRB and SEH) should have explored alternative and more appropriate interventions. While the APS worker stated that the client was resistant to assistance, there is no mention that chore or homemaker services were considered. The Dixon requirement to consider a temporary crisis facility seems to have been ignored.

Finally, this case illustrates the tragic effect of the absence of an interagency agreement between the CRB and APS, two agencies that necessarily cross paths often in serving Dixon clients. Such a gap could well be the precipitating cause of this client's hospitalization, even though doctors agreed she was not in psychiatric crisis.

## III. COMMUNITY OUTREACH BRANCHES (North & South)

The Community Outreach Branches (COBs) are mobile treatment units based at the two Community Mental Health Centers: North (NCOB) at 1125 Spring Road, N.W. and South (SCOB), at 1905 E Street, S.E. They fall under the purview of the Mental Health Services Administration. In March 1985, NCOB had a staff of nine mental health professionals and SCOB was staffed by seven mental health professionals and a secretary. During most of 1985, NCOB served a monthly average of 35 clients and SCOB, 55.

The job description for COB personnel, received from MHSA, states "the basic purpose" of the COB:

> to offer intensive, assertive, comprehensive services to severely and chronically mentally ill persons referred from other MHSA programs as needing more assistance than those programs can provide. Often, the most pressing reason for the referral will be the inability/unwillingness of the patient to regularly come to the center for treatment. Thus, the [COB] will be providing many services on an outreach basis. The ultimate goal of the [COB] is to enable patients to continue functioning in the community and to prevent/minimize the need for rehospitalization.

### A. STRENGTHS OF THE COBS

The 1982 site-visit team documented major deficiencies in outreach at the CRB (1982 Site Visit Report, p. 19) and at both CMHCs (Id., p. 28); the 1983 survey "found nothing changed" (1983 Client Care Report, p. 22). The March 1985 visit and follow-up identified some areas of improvement.

#### 1. North Community Outreach Branch (NCOB)

NCOB staff appeared to be a cohesive, smoothly operating team with good written and verbal communication among staff. The site-visit team found them fully knowledgeable about their

clients. They establish reasonable treatment goals and follow the clients into the community to ensure that daily needs are met. Staff work split shifts in order to provide evening coverage until 9 pm, five days a week.

The program manager attends shift-change meetings and frequently provides clinical guidance concerning services to clients. Interaction between the program manager and the staff appeared positive and supportive. The goals of the program were understood and accepted by the staff. Training at the Dane County Mental Health Center had been successfully adapted by these clinicians.

2. South Community Outreach Branch (SCOB)

SCOB staff also seemed to know their clients well. They, too, work split shifts in order to provide coverage until 9 pm, two days a week. Direct-service staff demonstrated an eagerness to provide outreach to the community and to shelters for the homeless.

B. PROGRAM ADMINISTRAITON

As at the CRB, the most serious problems observed in the COBs stem from poor administration.

The Dixon standards require all units to operate in a manner consistent with long-range goals and observable or measurable objectives identified in a mission statement. Standards, p. 4. Interviews revealed that staff at both outreach branches were aware of their programs' goals and the relationship of these goals to the Dixon standards. However, several administrative problems interfere with their achievement of these goals. These

problems are primarily in the areas of staffing and staff organization, policy definition, program evaluation and recordkeeping.

1. Staffing

Until July 1, 1985, the SCOB suffered from a severe shortage of physicians, identified in the March 1983 Client Care Report, p. 25. While the unit at last has adequate physician coverage, other staffing problems persist. For example, in May 1985, three of the nine direct-service positions at SCOB were vacant. As of December 31, 1985, these vacancies had not been filled. Another mental health counselor departed in December, leaving the SCOB short four of nine direct-service staff.

In addition, SCOB's current acting program manager was transferred from the direct-service staff to assume administrative responsibility for the branch. No apparent effort has been made to find a permanent manager, although this position has been vacant since June 1985.

2. Lack of a Team Approach to Treatment

The staff of both COBs received training at the Dane County Mental Health Center, a national model based on an interdisciplinary team approach to service delivery. However, of the eight SCOB staff members interviewed during the October 1985 follow-up visit, five cited the lack of a team approach to treatment as the primary problem affecting the unit.

During the March 1985 site visit, the team found no established framework for reaching solutions to client needs.

The interdisciplinary team concept of the Dane County program simply had not been integrated into the SCOB.

The absence of a team approach had been a problem at SCOB for some time. The MHSA administrator was aware of it and had conducted six weekly meetings with the SCOB staff. However, in October the situation was unchanged. For example, nursing staff took an exclusively medical approach while social service staff would refer the client only for educational services -- when what the client needed was a mix of these and additional services.

3. Administrative Sensitivity to Client Needs

The Dixon standards for staff recruitment and hiring, cited in full in Section B(4) above, state that staff must be sensitive to clients' needs and committed to their right to treatment. Standards, p. 6.

During the March 1985 site visit, the MHSA administrator informed the site-visit team that admissions to SCOB had been frozen because of the physician shortage. But the staff said, in interviews with the site-visit team, that the MHSA administrator had ordered admissions halted so that staff could catch up on overdue treatment plans before the site visit.

Further, differences of opinion between the (then) program manager and direct-service staff highlighted issues of power and control between the two groups. For example, the evaluation team observed a heated argument between the program manager and two staff members. The direct-service staff wished to visit a client who had missed an appointment, about whom they expressed great

concern. The program manager refused to authorize the visit, insisting that staff coverage be maintained at the unit.

4. Manual of Policies and Procedures

The Dixon standards require availability of a manual of internally consistent policies and procedures. Standards, p. 5. When the March 1985 site-visit teams asked about policies and procedures, the North CMHC chief of Adult Services and the director of South CMHC referred teams to the COB program managers. Very broad procedures (attached) had been developed by the MHSA administrator; the program managers were charged with developing procedures governing day-to-day operations, which they had done. The procedures they designed, however, were developed without consultation with CMHC branch managers and private providers and, accordingly, are often incompatible with other services or with the needs of Dixon clients. As was the case at the CRB, no internally consistent manual of policies and procedures was available for review.

5. Program Evaluation

The Dixon standards require "documented program evaluation activities which are adequate to determine whether the activities of service units meet current program goals and objectives" for service utilization, the process of service delivery, its cost, and personnel administration and staff development. Standards, p. 5.

While the MHSA has been diligent in reporting weekly the required data on service utilization and, semiannually, information on the use of financial resources, none of the

individuals interviewed could identify the objectives against which these data were to be measured. There was no evidence of any mechanism to assess the effectiveness or improve the quality of service delivery by the COBs.

Both COB units are currently operating far below the caseload of 150 difficult-to-treat clients anticipated for each unit by both the District and the Dixon Committee. Dixon Committee's 4th Annual Report to the Court, p. 6. As of November 18, 1985, SCOB had 66 clients and NCOB had 52. No reason was given for this apparent underutilization.

6. Recordkeeping and Treatment Planning

The Dixon standards for client service records and treatment planning pp. 12-16, are very specific. An individualized treatment plan (ITP) is a vital link in the continuum of care promised by the Dixon Plan (p. 2). Many of the client service records reviewed during the 1982 site visit were deficient in the areas of initial assessment, recordkeeping and treatment planning. 1982 Site-Visit Report, pp. 35-40. The same deficiencies were found during the March 1985 site visit and, again, during the October 1985 site visit and follow-up review.

During the October follow-up, four client service records from NCOB and 15 client service records from SCOB were randomly selected for review. All four from NCOB and seven of the 15 from SCOB lacked individual treatment plans. The ITP must describe the nature of the client's specific needs and capabilities, his program goals -- both short- and long-range -- and timetables for the attainment of these goals. It should address each client's

"residential needs, medical needs,...skill learning needs, psychological needs, social needs...and other needs as appropriate." Plan, p. 39.

As the following case illustrates, when treatment planning breaks down, the quality of care inevitably suffers.

> The 32-year-old client was referred to COB by his case manager, who indicated that the client was unwilling to come to the CMHC for appointments and medication. The client had a history of alcohol and drug abuse and numerous contacts with SEH. No ITP was found in his chart. The client was taking prolixin and stelazine, but no other types of services were indicated in the chart.
>
> On September 6, COB staff dropped off medication at the client's house and gave him instructions for its use. On September 9, his girlfriend called to inform COB staff that the client had been admitted to Howard University Hospital for an overdose of medication.
>
> On September 16, COB staff visited the hospital to see the client. However, the client had been discharged three days earlier.

The information in the ITP is meant to help clinicians assess and meet the client's needs. The absence of an ITP indicates a lack of planning. For a client like the one above, with a history of substance abuse, planning would have warned against the possibility of his overdose. But his record did not indicate that an explanation of the overdose was even sought. How were medications monitored? What plans were made for adjusting them? How would they be administered? If these questions had been addressed in the client's ITP the overdose and hospitalization might have been avoided.

7. Budget

The COBs, like the CRB, do not have their own budgets, though a budget for each unit is required. Standards, p. 8.

Interviews with the center directors and chiefs of adult services indicate that financial projections are based on existing and anticipated needs (primarily staffing needs) and are then submitted to MHSA. Funds are then allocated to the CMHCs without specific line items for individual units. As a result, both center directors and unit managers are unsure of how many dollars are available to meet which of a unit's needs. For example, both the manager of NCOB and her supervisor agree that the COB would benefit from a client-incentive fund -- e.g., to take clients out for coffee. Neither is sure, however, that such a request would be considered or approved, so no request has been made. To take another example, the program managers said that because the phone bill had not been paid, the mobile telephones in the cars used by the COBs had been disconnected. These telephones were not operating during the March 1985 site visit or the October 1985 and January 1986 follow-ups. As of March 3, 1986, the SCOB still does not have a working mobile telephone.

It appears that program managers have little of the required "input to the development of the budget" for their programs. Standards, p. 8. Further, they are not informed how much has been allocated or spent for their programs in a given year. This omission poses a serious obstacle to the growth of the program and disregards yet another important evaluation tool. Analysis of expenditures generates important data, which can be used to enhance the use of scarce resources.

C. SERVICE DELIVERY

The 1982 site visit found that the District's mental health system did not adequately serve people whose severe mental health and coping problems require intensive outreach and follow-along services to prevent hospitalization or other serious problems. 1982 Site-Visit Report, p. 1. The COBs were established specifically to fill these gaps in outreach and follow-up.

The following case examples illustrate continuation of the same deficiencies.

> On January 28, a client first seen in November 1984 returned to the COB to consider admission to its counseling program. On February 15, a school counselor called about the client, saying she had threatened to disappear with her school-aged children. The children had not attended school for several weeks and the client refused to admit anyone to her apartment. COB staff arranged to meet the school counselor in front of the client's apartment building on February 19, after the holiday weekend.
>
> When COB staff attempted a follow-up visit on February 26, the client refused to let them in. On March 4, the children were placed with the client's mother.
>
> At a competency hearing on March 7, the client was ordered to attend a COB program the next day for medication and treatment.
>
> A staff member reported that the client did not keep the March 8 appointment for medication, although this had not been entered on her chart as of March 14, when the site-visit team reviewed it. The staff member also said no further follow-up had been attempted.

In light of the noncompliance typical of most COB clients and the warning by the school counselor that this client was experiencing distress, the outreach efforts were simply too little and too late. Any unit or individual clinician who assumes responsibility for a client in distress or crisis is bound by the Dixon standards for crisis intervention to attempt immediate reduction of distress, not to postpone outreach until

the next workday -- especially if a three-day weekend intervenes. Standards, p. 36.

Another example shows how inadequate outreach and follow-up can result in hospitalization.

> A 63-year-old client with a variety of diagnoses has had numerous admissions to St. Elizabeths Hospital and usually drops out of treatment soon after discharge. She routinely reappears when family members are no longer able to cope with her behavior. She was admitted to the COB in November 1984 and the following treatment plan was developed: (1) weekly contact (phone) with family; (2) assist family as needed with patient; (3) provide emotional support to patient's mother; and (4) deliver medications and make home visit every 15-30 days.
>
> On January 11, 1985, the COB staff helped the family obtain an application for SSI. However, two weeks passed before the staff made a home visit to help the client's mother complete the application.
>
> A home visit by COB staff and psychiatrist was scheduled on January 30 for the next day, for reasons unspecified in the record. During the visit the client requested admission to St. Elizabeths. The doctor apparently agreed and the COB conveyed the client to the hospital.

For the most part, the treatment plan was followed, but the record contained no information to explain why hospitalization occurred. The team apparently had little input in the doctor's decision to hospitalize the patient. There was no evidence that alternatives were explored, or that outreach was as vigorous as is necessary with such historically noncompliant clients.

Another example of failure to provide adequate outreach is the case summarized in section III(B)(6) above, on recordkeeping. Although the COB was informed that the client had been admitted to Howard University Hospital for an overdose, the unit's staff made no attempt to visit him for seven days -- then found he had already been discharged. Although follow-up to clients is

critical to providing the continuity of care mandated by the Dixon Plan, the record gives no indication that anyone from COB ever spoke about the client with staff of Howard University Hospital.

## CONCLUSIONS

The Dixon Committee has reached two principal conclusions as a result of its site visits to and follow-up reviews at the CRB and COBs.

First, the deficiencies cited in the 1982 and 1983 reports persist. The District has failed to honor its April 1983 agreement to develop crisis resolution and community outreach services that fully comport with the Dixon Final Implementation Plan and program standards. The intensive treatment planning, outreach, follow-up and crisis intervention -- required by the Dixon Plan and standards and essential to minimize hospitalization and maintain severely disabled people in the community -- is inadequately provided by the existing units.

Second, although some improvements have been made, the numerous deficiencies that prevail in program administration three years after they were brought to light by the Dixon Committee and other experts indicate that the administrators responsible for these units are either incapable or unwilling to comply with the Dixon Consent Order and Final Implementation Plan.

The failings in program administration identified in this report point to (1) decision-makers' lack of commitment to meeting the needs of the chronically mentally ill people they have agreed to serve and (2) inability of the system's present leadership to develop adequate services for these Dixon clients. In addition to precluding implementation of the Dixon Consent Order and Plan for members of the Dixon class, these deficiencies also augur badly for the many chronically mentally ill people who

will need intensive crisis resolution and outreach through the unified mental health system now under development.

As the District continues planning for its mental health system reorganization, its leaders must remember that right now, thousands of mentally ill citizens need and are entitled to the community-based services promised by the Dixon mandate. Indeed, compliance with the Dixon plan and program standards, in addition to being a mandate of Public Law 98-621, offers the District an opportunity to demonstrate the ability of the new unified system to meet client need -- for example, by developing and executing the series of actions needed to meet the mental health, residential and support needs of the 300 Dixon clients now awaiting transfer from St. Elizabeths Hospital.

We urge the District to consider such a demonstration project in anticipation of the October 1987 reorganization of its mental health system. But whether or not it adopts this approach the District may not ask the members of the Dixon class to forego their established right to a continuum of appropriate mental health care while a reorganized system is in the planning stage.

Mr. WILLIS. Mr. Rosenberg.

## TESTIMONY OF NORMAN ROSENBERG, DIRECTOR, MENTAL HEALTH LAW PROJECT

Mr. ROSENBERG. Thank you, Mr. Willis.

My name is Norman Rosenberg. I am the director of the Mental Health Law Project, a public interest organization that has worked for 14 years to bring mentally disabled people under the protection of our Nation's laws and to generate appropriate services for them.

As you know, in 1974 the Mental Health Law Project brought *Dixon* v. *Weinberger*, an effort to establish an adequate system of community-based care for mentally disabled people in the District of Columbia. The Federal court's December 1975 order led to an agreement in 1980 by the Federal and District governments to plan for and implement a system providing a continuum of mental health services according to a detailed set of standards.

Compliance with this consent decree is mandated in Public Law 98-621, transferring St. Elizabeths Hospital to the District, and indeed is the basis for the preliminary system implementation plan that's before the committee today.

In Ms. Fleming's testimony this morning she commented on the Dixon committee's impatience with existing deficiencies in the service system, pointing out quite correctly that the District of Columbia is not responsible for taking over the full system until October 1, 1987.

I think it's important, however, to keep in mind that not only after October 1, 1987, but during the planning period itself, the planning period for the new integrated system, the District is not absolved of its responsibilities to fulfill the mandates of the Dixon decree which Judge Robinson has signed.

Unfortunately, the latest report by the Dixon committee, to which Dr. Stein referred, suggests that from top to bottom, with respect to a whole variety of services, the District has failed to fulfill its commitments to the court and to the citizens of the District of Columbia.

Unless the District begins immediately to correct the glaring and continuing deficiencies in its current provision of mental health care, as counsel for the Dixon plaintiff class we intend to return to court with our evidence of noncompliance and urge Judge Robinson to issue remedial orders requiring that the District operate its system in a manner consistent with the Dixon decree.

I want to echo Dr. Stein's congratulations to Ms. Fleming and her staff, made a moment ago. We all understand the difficulty of the task that Ms. Fleming and her staff face, and clearly she is to be congratulated for the effort that has been made.

At the same time, I, too, must emphasize that I think in some respects the plan falls far short of where it needs to be.

My remarks will supplement Dr. Stein's, but I do want to say that I concur with his statement for the committee, that the plan grossly underestimates the size of the Dixon class and does not assign adequate priority to the needs of many members of that class. Lack of attention to the needs of homeless people is, I agree,

totally unacceptable and absolutely requires rectification before October 1, 1987.

I want to mention a couple of other problems that Dr. Stein has not alluded to that we consider to be quite important.

The first has to do with the development of community residential facilities, and the second has to do with what we consider to be a serious inadequacy in the size of the budget or the budgetary projections for the new system.

First, let me talk about residential facilities.

When *Dixon* v. *Weinberger* was filed in 1974, NIMH survey documents had shown that nearly half of the St. Elizabeths population did not require institutionalization, and that their treatment needs could be better met in the community. But the obstacles to community placement were formidable. Chief among them was a lack of affordable, safe, well supervised residential facilities. Unhappily, 12 years later, the problem has not gotten better.

The preliminary plan holds out some hope for progress, but it doesn't go nearly far enough. It anticipates that by 1988 the population at St. Elizabeths will be reduced by about 50 percent, to just over 800 patients. But will the 800 patients who will leave the hospital return to the community? Under this plan, they will not. More than half of them will be moved from one building on the hospital grounds to another building on the hospital grounds. This is not community placement.

Let me talk about just one subgroup of this population. The plan acknowledges that 316 currently hospitalized adult patients are ready for outplacement, but 140 of them are slated for placement not in the community but in so-called swing-CRF's, transitional living units on the hospital grounds.

Further, in what could become a self-fulfilling prophecy, the plan states that if its goals of 80 placements for children and 255 for adults can't be achieved by 1988, alternative buildings on the campus will be used as temporary CRF's.

Now we recognize that some extremely disabled hospital patients may not be able to live in the community, and a more flexible homelike environment on the hospital grounds might indeed enhance their lives. But make no mistake about it: Moving patients who are eligible for outplacement from the ward of a psychiatric unit to a building called a swing-CRF does not comport either with the Dixon decree or with the principle of the least restrictive alternative on which that decree is based.

These people have a right to live in freedom. This means life in the community, with opportunities to interact and to learn from nondisabled people, free of hospital gates, guards and buildings. The people at the hospital have waited more than 10 years for this chance. They should not have to wait any longer.

We are concerned that, as so often happens, facilities which are designed as a kind of short-term solution to a problem, become a part of the longer term problem itself. We fear that development of residential facilities on the grounds of the hospital will simply lessen the urgency to develop housing that really is in the community. In my judgment, this would be a tragic mistake.

Now we all understand that the development of community residential facilities is a formidable task. Complex regulatory require-

ments and financial disincentives stand in the way, but these problems can be overcome, and it's the Government's obligation to ensure that they are overcome.

Communities' fears, based on ignorance and misunderstanding, can also be overcome by assuring proper distribution, monitoring and maintenance of these facilities. People often express fear that the value of their property will decrease if a group home for mentally disabled people moves into the neighborhood. Such fear is unfounded.

I have submitted, along with my written testimony this morning, an annotated bibliography that our office has compiled. It describes 26 research studies and 11 reports showing that the presence of a group home for mentally disabled people has no negative impact on neighboring property values. Indeed, values tend to increase at the same rate as in adjoining neighborhoods without group homes.

Let me turn now to some budgetary concerns. We are concerned that the boundaries established by the multiyear financial planning targets limiting the staff and facility resources to $162 million for implementation of the new plan is inadequate. That figure is used as the total in each of the 4 years of the transition period, 1988 to 1991. It is not realistic, given the planning goals outlined.

For example, the reorganization plan established as a planning target, that the public mental health system will double its service capacity by 1991 to 10,000 adult chronic mental health patients. To aim at doubling the number of chronically mentally ill adults served without increasing resources is simply preposterous.

Similarly, for children and youth, the plan says: "As a planning target the public mental health system should increase its caseload from 8 percent to 40 percent of the population in need of mental health services by 1991." Again, a likely fivefold increase in services with no apparent increase in resources.

Some of the inconsistency between resource commitment and planning targets can further be identified in the staffing assumptions. For example, the document states that 50 case managers will be initially hired to coordinate the therapeutic programs of 2,000 active outpatients. Initial staffing may comply with the Dixon requirement of an average ratio of 1 case manager to 40 patients, if you accept the assumption that only 2,000 people need service.

As Dr. Stein has just pointed out, however, we believe the District's assumption is substantially off target. But even assuming its accuracy, a target population of 10,000 adults and 5,000 children shows a need for at least 200 case managers by 1991, not 50 case managers. There appears to be, however, no room in the budget for the drastic and important increases in staffing that are needed.

Finally, let me say that from our perspective the test of a successful system is measured against not what is promised but what is delivered. The mentally ill citizens of our community have now waited for over a decade for the development of an adequate mental health system. The system simply does not exist today, and we are deeply concerned that the plan does not go far enough to ensure that that system will exist tomorrow.

Thank you very much.

[The prepared statement of Mr. Rosenberg follows:]

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STATEMENT

OF

NORMAN S. ROSENBERG, DIRECTOR

MENTAL HEALTH LAW PROJECT

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

OF THE

COMMITTEE ON DISTRICT OF COLUMBIA

U.S. HOUSE OF REPRESENTATIVES

PUBLIC HEARING ON THE

PRELIMINARY SYSTEM IMPLEMENTATION PLAN

FOR THE D.C.

COMPREHENSIVE MENTAL HEALTH CARE SYSTEM

MAY 22, 1986

Mr. Chairman, members of the subcommittee, thank you for the opportunity to appear here today. My name is Norman Rosenberg. I am the director of the Mental Health Law Project, a public-interest organization that has worked for 14 years to bring mentally disabled people under the protection of our nation's laws and generate appropriate services for them.

Our mission is national in scope. But because the District of Columbia is our home, we have always placed special emphasis on the needs of mentally disabled people in this community. In 1974, the Project brought Dixon v. Weinberger to establish an adequate system of community-based care for mentally disabled people in the District of Columbia. The federal court's December 1975 order led to an agreement in 1980 by the federal and District governments to plan for and implement a system providing a continuum of mental health services according to a detailed set of standards. Compliance with this consent decree is mandated in P.L. 98-621, transferring St. Elizabeths Hospital to the District -- the basis for the Preliminary System Implementation Plan before you.

Deficiencies in the Current System

I remind the committee that during this planning period for the new, integrated mental health system, the District has not been absolved of its responsibility to fulfill Judge Robinson's order. To underscore this point, P.L. 98-621 states:

> During the service coordination period, the District of Columbia and the Secretary, to the extent provided in the federal court consent decree, shall be jointly responsible for providing citizens with the full range and scope of mental health services set forth in such decree and the system implementation plan.

The latest report by the Dixon Implementation Monitoring Committee on March 13, 1986 on the operation of the Crisis Resolution Branch and the Community Outreach Branches, is the latest in a long series of reports demonstrating that the District is out of compliance with the Dixon decree. The report, which Dr. Stein submitted for the record, concludes:

> [A]lthough some improvments have been made, the numerous deficiencies that prevail in program administration three years after they were brought to light by the Dixon Committee and other experts indicate that the administrators responsible for these units are either incapable or unwilling to comply with the Dixon Consent Order and Final Implementation Plan.
>
> The failings in program administration identified in this report point to (1) decision-makers' lack of commitment to meeting the needs of the chronically mentally ill people they have agreed to serve and (2) inabiltiy of the system's present leadership to develop adequate services for these Dixon clients. In addition to precluding implementation of the Dixon Consent Order and Plan for members of the Dixon class, these deficiencies also augur badly for the many chronically mentally ill people who will need intensive crisis resolution and outreach through the unified mental health system now under development.

Despite our strong support for the District's efforts to have an integrated and comprehensive mental health system in place by October 1987, our first responsibility is to the members of the Dixon class who are currently without essential services. Unless the District begins immediately to correct the glaring and continuing deficiencies in its current provision of mental health care, as counsel for the Dixon plaintiff class, we intend to return to court with our evidence of noncompliance and urge Judge Robinson to appoint a special master to operate the hospital and

the community services system in a manner consistent with the Dixon decree.

The Proposed Plan

While the Mental Health Law Project remains deeply concerned about present inadequacies, the presentation of the District's plan to create a unified and comprehensive system has opened a new era - one holding out the promise that the District's mentally disabled citizens may at last have access to an effective and appropriate and humane set of services. My remarks today are directed to this potential.

We are pleased to commend Mrs. Fleming and her staff, the members of the planning and advisory committees and the work groups for their efforts.

Yet, at the same time, I must emphasize that the plan falls short. My testimony supplements Dr. Stein's and I concur with his statement for the Dixon Committee that the plan underestimates the size of the Dixon class and does not assign adequate priority to the needs of many members of the class. Its lack of attention to the needs of homeless mentally ill people is, I agree, unconscionable, and must be rectified. We are especially concerned that the plan does not specifically address the egregious existing deficiencies in services that have been identified by the Dixon Committee.

I will now discuss problems we see in three areas beyond those Dr. Stein has identified: (1) The development of community residence facilities, (2) early intervention for disabled infants

and young children and, (3) the inadequacy of the District's budget for mental health services. I will cite the specific suggestions we made to the City Council and the Mayor to help meet the urgent and legitimate aspirations of mentally disabled District residents and their families.

I. Community Residential Facilities

When Dixon v. Weinberger was filed in 1974, a National Institute of Mental Health survey had documented that nearly half the St. Elizabeths Hospital inpatients did not require institutionalization and that their treatment needs could be better met in the community. But the obstacles to community placement were formidable. Chief among them was a lack of affordable, safe, well-supervised residential facilities. Twelve years later, the problem is the same.

A. Housing on the Hospital Grounds

The preliminary plan holds out hope for some progress. But it does not go far enough. It anticipates that by 1988 the population at St. Elizabeths Hospital will be reduced by about 50 percent, to just over 800 inpatients. But will the 800 patients who leave the hospital return to the community? Under this plan, they will not. More than half of them (429) will be moved from one building on the hospital grounds to another building on the hospital grounds. This is not community placement.

Let's look at one subgroup of this population. The plan acknowledges that 316 currently hospitalized adult patients are ready for outplacement. But 140 of them are slated for placement

not in the community but into so-called swing-CRFs -- transitional living units on the west side of the hospital grounds. Further, in what could become a self-fulfilling prophesy, the plan states that if its goals of 80 placements for children and 255 for adults can't be achieved by 1988, alternative buildings on the west side of the campus will be used as temporary CRFs.

Some extremely disabled hospital patients may not be able to live in the community. And a more homelike environment on the hospital grounds might enhance their lives. But make no mistake about it: Moving patients who are eligible for outplacement from the ward of a psychiatric unit to a building called a swing-CRF does not comport either with the Dixon decree or with the principle of the least restrictive alternative on which the court's decision was based. These people have a right to live in freedom. This means life in the community, with opportunities to interact with and learn from nondisabled people -- free of hospital gates, guards and buildings. The people at the hospital have waited more than 10 years for this chance; they should not have to wait any longer.

We fear that, as so often happens, facilities designed as a short-term solution will become a long-term problem. We fear that development of residential facilities on the grounds of the hospital will lessen the urgency to develop facilities that really are in the community. This would be a serious and tragic mistake.

B. Stimulating Development of Housing in the Community

The proposed establishment of a Housing Development Unit "at the highest level of the mental health system" is a commendable idea. The description of the proposed unit's responsibilities, however, suggests that it is not seen as a strong advocate for the use of every available housing resource, but rather as a data-collection and community-outreach agency. We recommend that this unit have the authority not only to "work closely with" the Department of Housing and Community Development but to claim for homeless mentally ill citizens their share of public and publicly sponsored housing.

The plan proposes to create therapeutic hostels for mentally ill people who are seriously ill but do not need to be confined in institutional settings. Also suggested is the use of SROs and the development and operation by private providers of multiple-family dwellings. These proposals are inadequate. Transfer to SROs is not an option because the District has none. Further, though the plan encourages private providers to develop housing options for mentally ill people, it does not address the District's obligation to make habitable the hundreds of its units that are currently unoccupied.

We applaud the plan's propsal to extend the SSI housing supplement now available to CRFs to nonprofit agencies that arrange placement of mentally ill clients in apartments or with foster families. The additional payment of $132 per month above the SSI benefit will enable these organizations to expand the

supply of scattered-site living arrangements and reduce the number of CRFs needed. We think this approach is eminently sensible and have suggested to the City Council that it not wait until 1988, but include funds for the subsidy in the 1987 budget.

Finally, we see the need for the District government to become much more innovative in developing incentives for potential nonprofit sponsors of residences. These might include tax-forgiving schemes, donations of city-owned properties and auctions of city property.

C. Community Concerns

Development of community residential facilities is admittedly a formidable task. Complex regulatory requirements and financial disincentives stand in the way. But these problems can be overcome and it is the government's obligation to ensure that they are. Communities' fears, based on ignorance and misunderstanding, can also be overcome by assuring proper distribution, monitoring and maintenance of these facilities. People often express fear that the value of their property will decrease if a group home for mentally disabled people moves into the neighborhood. Such fear is unfounded. I am submitting with my written testimony an annotated bibliography the Mental Health Law Project has complied. It describes 26 research studies and 11 reports showing that the presence of a group home for mentally disabled people has no negative impact on neighboring property values -- indeed, that values tend to increase at the same rate as in adjoining neighborhoods without group homes.

II. Services for Infants and Children

The Mental Health Law Project has examined how several states have expanded early intervention programs for very young handicapped children and children at risk of developing disabling conditions. Early intervention consists of a comprehensive set of interdisciplinary services for infants and toddlers, designed to encourage normal developmental patterns, prevent disabling conditions from becoming more handicapping, decrease stress on the family and meet a child's individual needs within the family setting. A large percentage of the children served by early intervention programs are emotionally maladjusted or mentally handicapped.

A number of states require early intervention services to be available to all children from birth. In the District of Columbia, under legislation implementing the Education for All Handicapped Children Act (P.L. 94-142), appropriate education and related services are mandated beginning at age 3. We have recommended that the City Council consider lowering the age for this set of services to birth.

We have urged the Council, at a minimum, to provide the resources needed now to correct the gap in services in the therapeutic nursery program for children ages 0 to 5. According to the reorganization plan (page 150), upwards of 130 children may require services provided in therapeutic nurseries. However, the mental health system currently operates only one therapeutic nursery program serving about 20 children. The plan anticipates

raising the service level from 20 to 130 children by 1991. That is an unacceptable timetable for meeting the critical needs of this vulnerable population. The District should appropriate funds in the Fiscal 1987 budget to start closing this service gap, with a target of completing the job by 1988.

III. Budget For Mental Health Services

We are seriously concerned about the "boundaries" established by the multi-year financial planning targets, limiting staff and facility resources to $162 million for implementation of the new comprehensive plan. That figure is used as the total in each of the four years of the transition period, from 1988 to 1991. This is not realistic, given the planning goals outlined.

For example, the "organization plan . . . establishes, as a planning target, that the public mental health system will double its service capacity by 1991 to 10,000 adult chronic mental health patients" (page 80). To aim at doubling the number of chronically mentally ill adults served without increasing resources is preposterous.

Similarly, for children and youth, the plan says: "As a planning target the public mental health system should increase its caseload from 8 percent to 40 percent of the population in need of mental health services by 1991" (page 89). Again, an unlikely five-fold increase in services with no apparent increase in resources.

Some of the inconsistency between resource commitment and planning targets can further be identified in the staffing

assumptions. For example, the document states that 50 case managers will be "initially" hired to coordinate the therapeutic programs of 2,000 active outpatients. This initial staffing complies with the Dixon requirement of an average ratio of one case manager to 40 patients. However, a target population of 10,000 adults and 5,000 children implies a need for at least 200 case managers by 1991 (based on the planning assumption that half of the caseload will require independent case managers). There seems to be no room in the budget figures for such an increase.

We recognize that the budget plan calls for increased annual appropriations by the District as federal subsidies decrease. Because we are suggesting that these increases in city funding may be insufficient, we will also make some suggestions for offsetting the additions.

A. Expansion of Medicaid Coverage

The federal Medicaid statute (Title XIX of the Social Security Act) provides federal reimbursement for a broad range of medical services to low-income people. The federal share of D.C. spending on covered medical services is 50 percent. The plan appears to fully recognize the potential for reimbursements for inpatient care. The plan does not reflect any recognition of potential Medicaid reimbursement for a broad range of outpatient mental health services.

Our examination of the D.C. Medicaid state plan suggests that the District's coverage of mental health services does not take full advantage of the federal statute. For example:

* 12 states reimburse psychologists as autonomous providers; D.C. does not.
* Massachusetts and Pennsylvania, for example, reimburse psychiatric day treatment centers for social work services, pre-vocational services, occupational therapy and self-care; D.C. should recognize the value and cost-effectiveness of these psychosocial rehabilitation services.
* Legislation enacted last month, the Consolidated Omnibus Budget Reconciliation Act (PL 99-272) permits states to include case management services in their regular Medicaid plans for specific population groups. The District should immediately modify its Medicaid program to take advantage of this new reimbursable service to chronically mentally ill individuals.
* Further, reimbursement for a primary care case management system is available through a "waiver" approved by the Secretary of HHS under § 1915(b) of the Medicaid statute. The District has not applied for such a waiver., nor has it applied for a waiver under § 1915(c), to cover the cost of home- or community-based services if in the absence of such services patients would require the level of care provided by a nursing home.

We suggest that the Committee urge the District to explore fully all opportunities within the Medicaid program for increased reimbursements to the District's mental health system.

B. Mandated Mental Health Benefits Coverage Under Private Insurance Policies

Currently, 26 states require availability of one of two forms of mental health benefits in private insurance contracts. Twelve states require all health insurance policies offered in the state to include, at a minimum, a specified mental health benefits component. Fourteen states require insurance companies to offer a specified benefits package but permit subscribers to reject the coverage if they so choose. The question of state authority to require such benefits was resolved last year (Metropolitan Life Insurance Co. and Travelers Insurance Co. v. Massachusetts), when the Supreme Court upheld the validity of a Massachusetts law requiring insurance companies to provide minimum amounts of mental health benefits to all insured persons in the state.

Such a bill, sponsored by Councilman John Ray, has been pending before the City Council for over a year. We have encouraged the Council to enact legislation requiring all insurance policies written in the District of Columbia to include mental health coverage. Such a law would both reduce the caseload pressure on the public mental health system and provide additional revenue for the program.

This concludes my prepared testimony. I will be glad to answer any questions the Committee members may have. Thank you.

Mr. WILLIS. Thank you, Mr. Rosenberg.

Both of you have raised serious questions about the ability of the system to fulfill its intended plan. I think you'll agree that there is a difference between what should be done and what can be done. What should be done is that this country have as a priority the delivery of mental health care and appropriate medical services to all people who need it. We don't live in that kind of a system, and at the present time, as was mentioned before, this administration and the Federal Government and the Congress are not headed in that direction.

So we move from what should be done to what can be done. We also live in a city that has a fixed limitation on where it can expand. I understand, and I think I'm right on this, that there may be as much as a 7-year waiting list on housing, low-income housing available for families.

You're working with a priority list that works its way to include the mentally ill and the homeless. As you have considered the plan, I think it would be fair if you could tell us whether or not you have taken into consideration these other variables, that the District of Columbia is not, as other communities are. It does not have a county. It cannot extend itself in other directions. It has fixed limitations with regard to housing.

As we look for possibilities of housing people who are outplaced from the hospital, who are to be placed in CRF's, who are to be placed in appropriate community settings, where do we go?

You folks have looked at this, and I think we need your insight.

Mr. ROSENBERG. Well, I think there's no question about it, that the housing problem is an extremely serious one. We have two concerns. One is that there is very little indication that, at least to this point in time, the kind of leadership that is needed to stimulate the creation of new housing has not been present.

Now we don't mean to suggest that it will be possible to find a good, clean, adequate CRF for every person who is entitled to one. We suggest, however, that best efforts have not yet been made, and suggest further that, by structuring the plan in such a fashion so as to suggest that the housing opportunities will not be made available, what we're simply doing is relieving the pressure on those people out there who might respond and saying, it's OK to leave these people on the hospital grounds.

Again, Mr. Willis, I want to point out, we don't think this is easy, but there certainly are examples of places around this country that suffer, too, from a lack of available rehabilitated, unrehabilitated units in which to place disabled people, that progress—significant progress has been made, and progress which is much, much more significant, it seems to me, than that which we can point to here in the District of Columbia.

I was up in New York just last week talking with some people who were still involved with the Willowbrook litigation. Willowbrook—New York City suffers from, from what we all know, probably the most serious housing problems of any city in this country.

Within a year from now, Willowbrook will have been down—will have been reduced from a population of over 9,000 several years ago to about 250 residents. Now I'm not saying that the problems of out-placing mentally retarded people is the same as mentally ill

people. I'm not saying that Washington's problems are the same as New York's.

What I am saying is that we have failed to see the kind of leadership exerted to stimulate church group involvement, private sector involvement, to push them, provide some incentives to create and to develop some new housing. We have not seen that leadership exercised to this point, and we think it's badly needed.

Mr. WILLIS. I think the committee—we asked Mr. Joe Manus of the Mental Health Law Project to serve with us as we developed this legislation, and we have taken very seriously the Dixon implementation plan and the court mandated decree.

We also have to try to be realistic, and we don't want to end up with what has happened in New York, and that is the massive warehousing during the winter in armories and other places of deinstitutionalized Willowbrook patients.

We would like to see something more appropriate. I guess, what I'm asking you to do is the same thing that was suggested to psychiatrists and psychologists, and that is that you work with us in stimulating churches and other organizations to reach out and take hold of this situation, that the burden is no longer just public but it really is, unfortunately, a public-private responsibility. We need your help.

Dr. Stein, do you have any comments?

Dr. STEIN. Well, just to underscore what Norm talked about, housing, and to certainly agree that the District of Columbia has many problems unique to itself and, in fact, every community is different from any other. But in terms of the clinical intervention that these people require, that really doesn't vary a great deal. And in fact, the present reorganization plan in general terms describes exactly the kind of system required.

The problem is its specificity, as I mentioned earlier. I certainly disagree with one of the earlier witnesses. I think it was the person representing the American Psychological Association who may—I might be misunderstanding him, but it almost sounded like he said let's not pay attention to anything that goes on anywhere else and, in essence, reinvent the wheel for the District of Columbia.

I don't think that makes—I think that very much is known, and I think the present plan reflects that.

Mr. WILLIS. Ms. Brown, we were very concerned about employee rights. I think you will remember that—and counsel will remember along with me, that we were right ready to go onto the floor when we negotiated some of the employee rights. What do you see happening, as they're outlined in the plan?

Ms. BROWN. At this point, we continue to hope that employees will maintain certain benefits and rights of their current employment. We realize that, upon transfer to the District government, there will be additional rights such as the right to bargain for wages.

However, we continue to have concerns that those employees who go with a contractor again may lose some of their benefits unless those benefits are actually written into requests for proposals.

We also are concerned that, if the CRF's are all private, there may—some of our members may lose employment completely.

Again, that's why we underscored that there should be public as well as private community residential facilities.

Again, those workers would have certain rights of negotiation.

Mr. WILLIS. Thank you. I notice that you've expanded the Dixon to include the homeless. Is this an inference that I'm making, or have you expanded the Dixon to include homeless?

Mr. ROSENBERG. No. The Dixon class is defined as those people who are mentally ill sufficiently to either be in a hospital or have—be at risk for hospitalization, and I didn't include—we certainly did not mean to indicate the entire—everyone that is homeless falls into that class or is mentally ill.

We were taking conservative estimates of 25 percent of people who are homeless are seriously mentally ill. There have been a number of studies that vary from 20 to 40 percent.

Mr. WILLIS. Thank you. Counsel?

Mr. BARNES. Ms. Brown, as you recall, the major point of contention during the negotiations was the participation by labor, AFSCME, in the formulation of the plan. Have you found that the role of AFSCME on the labor-management task force and the planning committee have been adequate? Have your views and opinions been taken into account?

Ms. BROWN. In viewing the preliminary plan, we do still have some concerns about the levels of employees to provide services. We are not sure at this point of the total amount of contracting out, let's say, for security services, for housekeeping, for dieticians. I don't think the exact numbers have been formulated. But again, we have made recommendations, and I think at this time we have not seen our views completely addressed in the plan. But again, we will continue to work with the MHSRO and the city and the Congress to see that those problems are addressed.

For instance, we have found in the hospital that our members who are dieticians often notice mood or behaviorial changes, and we're not sure that a contracted employee who has not worked with patients would pick up those types of nonmedical, of course, but significant changes in patient mood. We would just hope that our experience would be included in formulating the final plan and any other suggestions that come from the city.

Mr. BARNES. Dr. Stein, Dr. Rosenberg, I assume that your views and opinions are received by the appropriate people as this plan is developed. Do you have any thoughts on how the deep concerns that you've expressed today might be better taken into account?

Dr. STEIN. As I testified earlier, Ms. Fleming and her committee really have been very open to discussing things with us, but not in really involving us. And we're really interested in trying to be as helpful and useful as possible.

That's why we're requesting that your committee strongly urge Ms. Fleming's committee to involve us in the planning process.

Mr. ROSENBERG. Well, from our perspective as lawyers in the Dixon case, we have few forums in which we can make our views known and attempt to bring about the kinds of changes that we believe are required by the consent decree in this case.

One forum is this committee, and we're making our views known here and certainly stand willing to assist committee staff in any

way in which the concerns which we have expressed can be somehow incorporated into revisions of the plan.

Our other alternative as lawyers is to use the litigation in this case as a vehicle for trying to bring about compliance in areas where we believe nonco· pliance can be proved. We have been reluctant to use that forum for quite some time.

As Dr. Stein points out, on behalf of the committee—I think it's true for myself as one of the lawyers in this case—we have felt that the MHSRO needed time to proceed at its pace with its constituencies and to do the planning effort unencumbered by the threat of returning to court or any other judicial remedies.

We, however, have made a decision that we will not sit by for much longer. We are concerned that, once the appropriate signoffs have been—have taken place, that the plan will be a reality, and that our class members will have very few opportunities to try to effect the design of that new system.

So that is why I mentioned here that, unless we can begin to see some kind of improvement—and we will certainly try to do that through negotiations with Ms. Fleming's office and with members of the D.C. government. Unless we can begin to see some kinds of improvement in the existing service delivery system, we see ourselves as having no option but to try to seek some additional relief from the court.

Mr. BARNES. OK. We want to thank all three of you for your forthright testimony, and assure you, as Mr. Fauntroy did, that the committee will continue to perform its responsibility and its role in this process as it develops, and your comments have been helpful in those deliberations.

Before adjourning this hearing, Mr. Fauntroy wanted to acknowledge several organizations who have submitted written testimony which will be entered into the record without objection: the Friends of St. Elizabeths Hospital, the National Federation for Biblio/Poetry Therapy, the Physicians Association of St. Elizabeths Hospital.

Also, Mr. Fauntroy referred earlier to testimony presented before the city council and various public forums held by the city which will also be entered into the record without objection.

[The statements of the Friends of St. Elizabeths Hospital, the National Federation for Biblio/Poetry Therapy, and the Physicians Association of St. Elizabeths Hospital follow:]

[The prepared statement of the Friends of St. Elizabeths Hospital was not received in time for printing.]

**NATIONAL FEDERATION FOR BIBLIO/POETRY THERAPY**

EXECUTIVE SECRETARY: Deborah Langosch, ACSW
225 Lincoln Place, 2F., Brooklyn, N.Y. 718-636-0754

Arleen Hynes, O.S.B., C.P.T. President
National Federation for Biblio/Poetry Therapy
St. Benedict's, Box 156,
St. Joseph, Minn.

Mr. Ron Willis
Congressional Staff
Congressman Stewart McKinney
Committee on District of Columbia
1310 Longworth House Office Building
Washington, D.C.

Dear Mr. Willis,

My friend of many years, Mr. Dick Greer, now of the National Alliance for the Mentally Ill, told me of your care full, guiding work in the legislation concerning the reorganization of St. Elizabeths Hospital from a Federal to a District of Columbia facility.

I am proud to say that I was the librarian-bibliotherapist at St. Elizabeths Hospital in the Circulating Library (the patients' library) from 1970 to 1980. I initiated and developed the Bibliotherapy program and the Bibliotherapy Training Program while there. I also saw the statistics for annual number of patrons coming into the Circulating Library to use the books, records, and magazines go from 3000 (1969) to 30,000(1980).

In the accompanying letter to Congressman McKinney, who serves on the District of Columbia committee, and will, as you know, be reviewing the reorganization of services, I have made a case for the Bibliotherapy program and the Bibliotherapy Training Program, which is unique. It seemed best to restrict my concern in the letter to him to that issue, which is highly significant.

However, I also find myself deeply concerned about the public facility used more than the large recreational building. True, whole groups are scheduled for Hagan Hall, but for the individual patient at St. Elizabeths who seeks a relaxing place to get off the ward and stimulate his/her mind and spirits, it is to the Circulating Library they turn. It is situated in a lovely historical building and the staff makes it a welcoming place. Bibliotherapy sessions are also held there from time to time, and the bibliotherapy resource files and books, of course, housed there. Patients are respected and welcomed there, which certainly will not be the case in the downtown Martin Luther King library, or in the branches.

I appreciate any consideration you can give to these two matters, and I welcomed Dick Greer's suggestion that you would be alert to the needs of patients.

Sincerely,

(Sister) Arleen Hynes

Arleen Hynes, O.S.B., C.P.T.
President
National Federation for
Biblio/Poetry Therapy



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**NATIONAL FEDERATION FOR BIBLIO/POETRY THERAPY**

EXECUTIVE SECRETARY: Deborah Langosch, ACSW
225 Lincoln Place, 2F., Brooklyn, N.Y. 718-636-0754
May 1, 1986

Congressman Stewart B. McKinney
Committee on District of Columbia
1310 Longworth House Office Building
Washington, D.C.20510

Dear Congressman McKinney,

This letter concerns the specific issues of the continuation of the Bibliotherapy services and the non-stipended Bibliotherapy Training Program at St. Elizabeths Hospital, Washington, D.C., when the reorganization you will be reviewing will be completed.

Those of us who are concerned about the future of a high quality of patient care at St. Elizabeths Hospital realize that you have a deep personal commitment to that same goal. It seems to many mental health specialists that the continuation of these specific services are vital to that overall goal.

However, since bibliotherapy, or biblio/poetry therapy as it is now frequently called, is an innovative modality, it is quite possible that you would not think to inquire about its continued service to patients in the upcoming reorganization. It is for that reason that I would like to present some background information about the field.

Bibliotherapy and the non-stipended Bibliotherapy Training Program are part of the Division of Clinical Support Programs. As you know, the Clinical Support Programs guarantee patient care of a rehabilitative and healing nature, beyond the minimal custodial care. Without the Clinical Support Programs the daily growth of the patients who are too ill to leave the Hospital is hindered and the lives of out-patients limited.

To begin with, a definition of the term bibliotherapy might be useful to you. In bibliotherapy, or biblio/poetry therapy, the therapist uses literature and creative writing as a catalyst to stimulate the imaginative, emotional, and integrative processes for better utilization of individual strengths, self-awareness and growth.

The Bibliotherapy services and the Bibliotherapy Training Program have unique significance for this creative arts therapy. The non-stipended Training Program in particular has been a pace-setter for the field. It is the first, and unfortunately, the only curriculum-based hospital training program in the field. The Program has served, since 1974, as a prototype for components required for standard setting of the budding profession. The National Association for Poetry Therapy adopted them when they revised their standards for the C.P.T. (Certified Poetry Therapist). While the St. Elizabeths Training Program only gives a record of attendance, the N.A.P.T. recognizes its value and awards a C.P.T. to those who have completed

the 440 hours of the Program. The National Federation for Biblio/Poetry Therapy is currently establishing criteria for both Certification and for the new more demanding level of Registration. In both cases standard-setters have relied heavily on examining the desirability and feasibility of these components as identified in the experience of the supervised work of trainees in the St. Elizabeths Program.

Our field is most fortunate to have received the same nurturing cooperation from leaders in the mental health field who staff St. Elizabeths Hospital as did Miriam Chace when she developed the creative arts field of dance therapy back in the 1940's. St. Elizabeths has a long tradition of being receptive to new approaches which further its passion for developing ever-more effective ways to provide "humane care" as established by its founder, Dorothea L. Dix.

As of now, it is very important to the continuation of a high level of dedication to the field to mention that Mrs. Rosalie Brown, C.P.T., is presently the Bibliotherapist and directs the Bibliotherapy Training Program. Mrs. Brown was the first person to complete the 440 hour Program, and to hold the first Federal bibliotherapist's position (1976). She continues to carry on the program by serving patient groups herself, and also to conduct the Training Program. Four trainees are currently rendering biblio-therapy services to supervised groups of patients weekly on a volunteer basis. Eleven individuals have satisfactorily completed the two-year curriculum. Over the years several hundred patients have benefited from bibliotherapy services. In these cases, the bibliotherapy program has worked with low-functioning, long-term patients, among others. These are the kind of patients many find difficult to work with and yet are the very ones greatly in need of the kind of outlook bibliotherapy encourages--that of looking to wholeness and the strengths of the individual rather than focusing on problems. They are also the kind of patient who will very likely continue to need hospital care when the reorganization is completed.

Enclosed are an annotated bibliography and copies of articles that cite and describe hospital bibliotherapy programs. Some will help establish the historical perspective of the bibliotherapy services and Training Program. Others will deal with theoretical issues. Hopefully, they will clarify your understanding of the creative arts therapy of biblio/poetry therapy, and lead you to a sense of commitment to continue the biblio-therapy services and the Training Program at St. Elizabeths Hospital.

Sincerely,

Arleen M. Hynes, O.S.B., C.P.T.
President
National Federation for
Biblio/Poetry Therapy

**NATIONAL FEDERATION FOR BIBLIO/POETRY THERAPY**

EXECUTIVE SECRETARY: Deborah Langosch, ACSW
225 Lincoln Place, 2F., Brooklyn, N.Y. 718-636-0754

A SELECTED ANNOTATED BIBLIOGRAPHY ON BIBLIOTHERAPY

ARTICLES CITING THE ST. ELIZABETHS HOSPITAL PROGRAMS

Brown, Rosalie, C.P.T. 1977. "Bibliotherapy as a technique for increasing individuality among elderly patients." HOSPITAL AND COMMUNITY PSYCHIATRY, 28.5 May 1977: 347.
Describes responses to bibliotherapy by patients at St. Elizabeths who were physically handicapped, long-term residents.

Brown, Rosalie, C.P.T. 1985. Review of POETRY AS HEALER on back cover of the new book indicating her status as a respected professional.

Sweeney, Daniel, Ph.D. 1978. "Bibliotherapy and the elderly." in Rubin, Rhea. BIBLIOTHERAPY SOURCEBOOK. Pheonix, Az. Oryx Press. pp. 179-84.
A clinical psychologist at St. Elizabeths provides a theoretical base for a bibliotherapy program with a group of low functioning patients and gives examples of the kilnds of responses made in the group. These are the kind of patients who will not be immediately ready for out-patient programs when the reorganization is finalized.

Marr, James. 1983. "The capacity for joy." NURSING TIMES, September 21,1983. pp.58-60-62.
Mr. Marr, a Scottish teacher of nursing, wrote this article on the program he based on Dr. Sweeney's and R. Brown's articles about their experiences, demonstrating the far-flung influence of St. Elizabeths bibliotherapy program.

Hynes, Arleen M.,C.P.T. c 1975. "Bibliotherapy in the Circulating Library at St. Elizabeths Hospital." In Rubin, Rhea. 1978. BIBLIOTHERAPY SOURCEBOOK. Ibid. pp. 300-04.
A documentation of the early years of the bibliotherapy program at St. Elizabeths.

Hynes, Arleen M.,C.P.T. c 1976. "Certification and the St. Elizabeths Hospital bibliotherapy training program." In Rubin, Rhea. 1978. USING BIBLIOTHERAPY. Pheonix, Az. Oryx Press. pp.202-12.
Explicates the components of the Training Program. These standards set the pace for the basic items presently being adapted by the National Federation for Biblio/Poetry Therapy. These components are: 1)study of the literature of the field, 2) peer group experience of developmental bibliotherapy by the trainees, 3) experience facilitating groups of participants in the bibliotherapy process as a major dimension , 4) continuity of experience working with the same kind of participants for a year, 5) a second extended period working with another type of participants, 6) group supervision conducted by a mental health specialist , 7) individual supervision of work with participants, 8) reports made to supervisors.

p.2 Selected bibliography on bibliotherapy

Allen, Barbara. 1981. "Bibliotherapy and the disabled." DREXEL LIBRARY QUARTERLY. April 1981, 16.2: 81-93.

A trainee, who later directed a public library bibliotherapy program for the aging in California, writes about bibliotherapy and cites insights and examples from her St. Elizabeths Hospital experience.

Ensler, Helen. 1982. "Bibliotherapy in practice." LIBRARY TRENDS: Special Issue: Mental Health, information libraries and services to the patients. Spring 1982: 647-659.

A Massachusetts state mental institution bibliotherapy program in the library is described. The partially federally funded program demonstrates the adaptability of bibliotherapy to other institutions. Cites St. Elizabeths Training Program.

RECENT BOOKS

Leedy, Jack J., M.D. 1985. POETRY AS HEALER: MENDING THE TROUBLED MIND. New York. Vanguard.

A valuable collection of articles that have appeared since 1969 on the use of poetry as one genre of literature that has proved to be very effective in the clinical work of psychotherapists and in developmental work by therapists, counselors, and teachers.

Hynes, Arleen M. 1986. BIBLIOTHERAPY, THE INTERACTIVE PROCESS: A HANDBOOK. Boulder, Co. Westview Press.

The first teaching manual for the education and training of biblio/poetry therapy. Provides theoretical background materials that apply specifically to biblio/poetry therapy.Developed to fill the need perceived in developing the Training Program at St. Elizabeths.

BIBLIO/POETRY THERAPY IN THE MENTAL HEALTH FIELD

DIALOG SEARCH, A PSYCINFO DATA BASE

Dated October 1983 listed 172 current articles and books on bibliotherapy and poetry therapy.

This indicates that professionals working in the fields of psychotherapy, counseling, nursing, occupational therapy, recreational therapy, social work , and librarianship are using biblio/poetry therapy techniques as described in these articles.

## BIBLIOTHERAPY IN REVIEW

Definition: BIBLIOTHERAPY USES LITERATURE, AUDIOVISUALS, AND/OR CREATIVE WRITING AS A FOCUS FOR A GUIDED DISCUSSION ABOUT THE FEELINGS AROUSED BY THE MATERIALS. IT IS THE CREATIVE INTERACTION BETWEEN THE LITERATURE, THE INDIVIDUAL(S), AND FACILITATOR THAT HELPS INDIVIDUALS BECOME MORE FULLY AWARE OF THEMSELVES AND LEADS TO INCREASED UNDERSTANDING ABOUT HOW TO UTILIZE ONE'S POTENTIAL.

Taken from Arleen Hynes, 'O.S.B. definition in the forthcoming: HANDBOOK FOR CLINICAL AND DEVELOPMENTAL BIBLIOTHERAPY: A LEARNING MANUAL FOR CLASS AND SELF-STUDY. Westview Press, 5500 Central Ave., Boulder, Co. 80301.

## BIBLIOTHERAPY ORGANIZATION

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| **American Academy for Poetry Therapy** Morris R. Morrison, President, Suite # 424 255 Congress, Austin, Texas 78701. | Offers training, and a record of attendance. |
| **Bibliotherapy Discussion Group of the Association of Specialized and Cooperative Library Agencies, a division of the American Library Association,** c/o A.L.A., 50 E. Huron St., Chicago, Ill. 60611. $5.00 a year for A.L.A., $7.00 for anyone interested in membership. Newsletter and directory. | Meets twice annually at the American Library Association Mid-Winter and Annual Convention Newsletter. |
| **Bibliotherapy Round Table,** c/o Arleen Hynes, O.S.B., St. Benedict's, St. Joseph, Mn. 56374. | Not-for-profit. Offers workshops, courses, supervisory evaluations. Not a membership organization. |
| **Institute for the Study of Bibliotherapy, Inc.** Sister Mirian Schultheis, O.S.B., President. 724 W. 4th St. Fort Wayne, Indiana 46808. | Not-for-profit. Engages in reading education using bibliotherapy. Not a membership organization. |
| **National Association for Poetry Therapy.** Membership to Beverly Harris Bussolati, 1029 Henhawk Rd., Baldwin, N.Y. 11510 $20.00 a year. Annual meeting. Newsletter. | Not-for-profit membership organization. Annual meeting. Newsletter. |
| **Poetry Therapy Institue,** P.O. Box 702 Los Angeles, CA. 90070. Arthur Lerner, Ph. D., President. | Not-for-profit, training institute, letter of record of attendance. Offers courses and workshops. Not a membership organization. |
| **Ohio Poetry Therapy Center and Library** 2384 Hardesty Drive So. Columbus, Ohio 43204 | A regional group of N.A.P.T. members who hold workshops and discussions. Write for more information. |

BIBLIO/POETRY THERAPY

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# BIBLIOTHERAPY AS A TECHNIQUE FOR INCREASING INDIVIDUALITY AMONG ELDERLY PATIENTS

*Rosalie M. Brown, C.P.T.*

After working 21 months with a group of elderly wheel-chair patients, I am convinced that bibliotherapy is not only possible but highly effective even when some patients cannot speak. With the help of an understanding nursing assistant, I have watched institutionalized men on a medical ward of a mental hospital emerge as individuals through a group experience that provides enjoyment, empathy, humor, and group discipline.

My involvement grew out of a wish to stimulate an interest in life for an aged man I met as a volunteer. I was giving out magazines on wards, and the *National Geographic* provided the vehicle for conversation between us. Critically ill, he was engaged in a life review, and he later confided that his priest, through religion, and I, through literature, had enabled him to find fresh interest in living.

As a result, I was asked to form a bibliotherapy group, but, in contrast with my other bibliotherapy groups, this one consisted of seven men confined to wheel chairs and with varying capacities to speak. In the first session, we extended a warm invitation through Robert Frost's poem *The Pasture* and its refrain of "You come, too." The men imagined themselves patting a calf, smelling the air, feeling a cool spring, and seeing their faces reflected in the water. Magazines and pictures gave them a choice of places to which they would like to be invited: a circus, a boat off by itself, a cruise ship, a place with food. We encouraged patients whose speech was extremely limited or nonexistent to use their arms and hands in pantomime. The men accepted an invitation to form a continuing group.

When the men gathered for the second session, each identified himself at once in the framework of Lois Lenski's poem *People*. They decided what kind of town they would like to live in. As they indicated what skills and contributions they thought they could offer the town, their individuality became clear.

During successive sessions, we met around a table, to give us a place for magazines and props, to foster group solidarity, and to minimize the consciousness of sitting in wheel chairs. The slogan "Let's all pull together," adopted by citizens of Kenya, caught the men's imagination. Those who could not speak learned to express it with gestures, and eventually all the patients would express it spontaneously.

A little later the poem *The Flag Goes By*, by Henry Bennett, was read aloud; it elicited from various members a military salute, a civilian salute, and, from a severely spastic patient, an attempt at a Boy Scout salute. Members were reminded of football games, and of musical bands that would "stink" if members did not follow the group slogan to pull together.

Members themselves then began to suggest the men, birds, fish, music, people, and places in Washington. James Metcalfe's poem *Washington, D.C.*, as well as excerpts from the preamble to the Declaration of Independence, opened the way for members to express how they felt about being patients in a mental hospital—their attitudes toward family and neighbors, their awareness of restricted freedom, their desire to go home, their wish to break up their wheel chairs. Some wanted to be free to look for work, some to simply wander off.

Learning that Clara Barton was once afraid of people and experienced recurrent difficulty in speaking gave members courage to share their fear of doctors and of hearing voices. Influenced by Miss Barton's example, they began to encourage each other to try to make appropriate sounds.

With the approach of the holidays, one patient's exclamation that "Christmas is dead when I'm afraid to live" led to talk of death and the men's mixed feelings toward the special season. Through stories, poems, and good wishes for each other, they found support among themselves. On Christmas morning I visited them and gave each a covered wagon tree ornament to hang on his wheel chair, reminding them of our slogan.

Despite loss by death and the addition of new members, this group remains a highly cohesive circle throughout the week as well as during the sessions. Members remember when we are to meet, and several laboriously roll themselves to our meeting place in order to arrive ahead of me. Once a member confined to bed wanted so much to be included that we gathered around his bed for that week's session.

The group reminisces, cries, laughs, and at times teases. When we started, members were indignant if their wheel chairs accidentally bumped or they happened to touch one another when making signs with their hands. Now members freely pass pictures and objects among them, though poor coordination makes the process agonizingly slow for some. Members also exercise group discipline; public use of urinals is out, and the intrusion of nonmembers is discouraged.

Besides using magazines and pictures to express personal preferences, the patients have acquired ability to pantomime imaginatively. Rhythm poems give them practice in shaping sounds. One man previously unable to make recognizable sounds now does so, drawing on his own determination and the help of others to make himself understood. Group members look at each other as they speak. They listen with care. Communication, verbal and nonverbal, is a group venture rather than an individual struggle.

Ms. Brown, a certified poetry therapist, is a bibliotherapist at St. Elizabeths Hospital, Washington, D.C. 20032, and is the first bibliotherapist in the federal system.

Nursing Times, September 21, 1983
(A Scottish therapeutic activity based on articles about bibliotherapy at St. Elizabths Hospital)

# The capacity for joy

*James Marr describes how bibliotherapy uses books and photographs to stimulate the interest of groups of elderly psychiatric patients*

'FOR age is opportunity, no less
Than youth itself, though in another dress
And as the evening twilight fades away
The sky is filled with stars, invisible by day.'

*Henry Wadsworth Longfellow*

I wonder how many of you know how to make an inexpensive champagne cocktail? Or how to walk in a hobble skirt? Who has met Bob Hope or Eric Liddell (of *Chariots of Fire* fame)? Have you seen Mahatma Gandhi in real life? Can you speak Russian, Esperanto or Italian? Have you experienced the grief or frustration which folk , a stroke? What do you fear most about death?

These are just a few of the many topics we have discussed during the last six months at our weekly bibliotherapy group sessions with elderly patients, all of whom are over 65. One group consists of patients in our long-stay ward, the other of people attending our psychogeriatric day hospital. Diagnoses include schizophrenia, dementia, cerebrovascular accident and multiple sclerosis. Nursing problems include hearing loss, dysphasia, blindness and confusion, yet these patients have given so much of themselves and taught us so much it has been a privilege to spend time with them. It is normally thought difficult to do anything with this type of patient, or interest them in anything, yet bibliotherapy has worked successfully.

What is bibliotherapy? The word actually means 'book therapy' but we have also included poetry, music, pictures, china and photographs. Daniel Sweeney[1] claims that bibliotherapy 'seeks to tap a person's capacity to experience joy in his life'. Most other therapies deal with the pathology of a person but bibliotherapy begins with a thing of beauty and seeks some response to it. Elderly patients have enough problems and worries in the present without dredging more from their past; bibliotherapy, therefore, deals

directly with the healthy, positive aspects of their character and experiences.

Patients benefit from it, as do trained staff, untrained staff and students, who also learn how to provide better and more holistic care. It entails no cost and needs no extra staff or equipment, so it is guaranteed to be popular with administrative staff too.

Let us tell you how we were first introduced to it. Sweeney's article *Bibliotherapy and the elderly* interested Jean at the psychogeriatric day hospital and we decided to set up a group as an experiment for some of the patients. It was hoped that this would also free some places at the day hospital and relieve pressure.

This group had to be reasonably physically fit, as most of them would be

asked to make their way to the hospital independently, and solely to attend the Wednesday group once it was firmly established (at the beginning transport was provided for everyone).

The participants were Miss W, 72, a manic-depressive woman living alone; Miss S, 70, depressive with an alcohol problem, living with her demenring sister; Miss L, 75, a manic-depressive, retired school teacher; Miss P, depressive with a paranoid personality and low self-esteem due to kyphosis, who lives alone; Mrs M, 70, depressive following a stroke and living alone; Mrs Mac, 77, depressive; Miss B, 72, depressive following a stroke and living with her sister who is severely demented; Mrs S, 70, depressive and over-protected by her husband; Mr L, 70, with a depressive illness; Mr J, 75, hydrocephalic (had a shunt inserted) with mild dementia and depressive symptoms, lives with his wife; Miss C, 86, depressive with suicidal tendencies and living alone; and Miss W, 70, depressive with mild dementia, a retired school teacher.

Eight of these people have firmly remained in the Wednesday group. One woman has been discharged, two have been admitted to long-term care following further disabilities and one was unsuitable for this kind of group. As the setting we chose a pleasant room with a fireplace, comfortably furnished with easy chairs and a coffee table, with two windows facing the garden. That was our room each Wednesday from 1.30 to 3pm.

We supplied fresh flowers each week and made tea, with a selection of chocolate biscuits or a home-made cake—as time went on, the patients brought flowers from their gardens and even baked their own special favourites. Tea is taken halfway through the afternoon. Staff wear their own clothes instead of uniforms in order to be one with the group.

We have always welcomed visitors, and student nurses, medical students, occupational therapy students and social work students have at times been with us, either making a valuable contribution or just listening.

The aim was to restore the feeling of belonging and increase a sense of fellowship and participation. It was to allow people to express their thoughts of joy or sorrow and share it in this group with those who had similar problems.

We talked about life at the turn of

the century, and about new inventions—especially television—and how they brought us closer to the rest of the world by allowing us to see changes almost at first hand. We talked about violence, test-tube babies, artificial insemination, death, the family unit, young people of today, how to make champagne cocktails and 101 other subjects.

At the beginning people were quiet and shy with each other, but we supplied many props like paper cuttings and photographs of long ago, poetry and music. When conversation was still forced and difficult we encouraged people to put their thoughts to paper—we had it typed and circulated photocopies during our next Wednesday meeting.

We reached a stage where the group had gained some confidence and supplied their own props—old photographs, articles of interest, newspaper cuttings and information of common interest such as pension increases, or bus passes. At that time social services were drawing up plans for cuts and Miss P actually attended two of the council meetings, reporting back to the group and supplying us with leaflets and useful information. We had reached a stage where every member of the Wednesday group gave freely of themselves and felt much more confident.

No agenda was now necessary. 'If one comes to the group determined to discuss a subject, disappointment blocks the independence of the group,' as Dr Sweeney points out.

Headings from books like *The Virus in Winter* by Ronald Blyth, Joyce Grenfell's *Stately as a Galleon*, Palgrave's *Golden Treasury* and *The Book of Oxford Quotations* stimulated our conversation. This often brought to the surface serious problems which had never been discussed before—the break-up of families, bereavement, the lack of financial support, the frustrations of being unmarried and childless, concern about illness and how to cope without much family support, the prospect of giving up independence if they became too frail to look after themselves.

Perhaps most of all it fulfils the need to reminisce, to compensate for the loss of confidence, to remind others that they have their own past achievements. It gives listeners insight into past coping behaviour. The group is mainly intended to allow patients to talk, but it is also interested in the group leaders and staff, showing particular interest in our families, hobbies and interests. We felt we wanted to, and should, give of ourselves, as we had at the beginning decided to make it a closed group. This would lend itself to more intimacy, allowing members to build up a special trust with each other knowing that whatever was discussed would be confidential.

This experience of a bibliotherapy group has been hard work and demanding, but most of all it has been fun and joy. We have created group identity; loneliness and isolation, sometimes at least, are dispelled and people have a forum in which to speak. Friendships have developed; people have become more aware of each other, realising that everyone has something to give. Staff relations have improved, and even staff not involved respect the fact that Wednesday afternoons are reserved for bibliotherapy.

FOLLOWING the success of the initial bibliotherapy group, and experiencing some frustration at the care we were giving patients in our long-stay ward, it was decided to expand our concept and set up a group for these patients.

We agreed that all patients should be invited to attend but we knew some would not want to, and others would be unsuitable, mainly due to severe organic impairment. It proved difficult to find a quiet corner in the ward where we would be undisturbed and able to concentrate, but eventually we used one of the six-bed bays which was empty by late morning. We decided that 11am till midday was the best time for patients and staff, and that the group should be treated as a priority and not be the first to suffer from staff shortage or sickness.

We found that eight patients were keen to attend and were suitable: five patients were stroke victims, two had mild depression and one had had an amputation. Most also had some degree of sensory deprivation ranging from hearing loss and dysphasia to blindness. One patient managed to make her own way to the group with her Zimmer frame, the rest were transported by wheelchairs from the day room.

We found it best to huddle together in a fairly tight circle so that all could see and hear as well as possible. Staff interspersed themselves in the circle to amplify and clarify speech, to ensure continuity and prevent anyone being left out. After the first few meetings it became evident that some staff not used to groups needed some help and advice, and simple guidelines were pro/ ed as follows.

THE aim of the group is to encourage the patients to talk and share the past and present positive experiences of their lives. In this way it is hoped to restore their morale and to replace feelings of despair with hope and confidence.

Although we wish the time to be free and relaxed, the following are guidelines which staff should remember:

1. Members of group and staff should be introduced and a brief explanation given.

2. One person should speak at a time to encourage one strand of conversation (which the patient will find easier to follow).

3. Allow the patients plenty of time to express themselves, and avoid putting words into their mouths.

4. Staff should be interspersed between patients to help those who are hard of hearing and to prevent a 'them and us' situation occurring.

5. Conversation should be relaxed and free and should always be directed towards patients' experiences, unless patients ask staff about their own experiences.

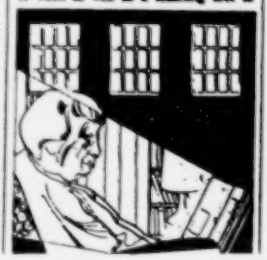
One of the aims of the group was to encourage patients to interact with each other and to foster some degree of empathy. We decided, therefore, to begin by finding out common denominators. We introduced ourselves and were amazed to find how many did not know or recognise each other after years under the same roof. Conversation focused on birthplace, employment and places of residence. Even after one session many similarities and common denominators were identified, and for the next few weeks no props or stimuli were required.

We began to read pieces of poetry later, but this was not too successful as the patients forgot it almost as soon as it was read. We found that pictures or articles they could see and discuss were better.

We talked of the Falklands crisis, of the anxiety they experienced and the memories it stirred; the Royal Family; past fashions; the Pope's visit; tramcars; grief; loneliness; stroke and death. We used the group to choose new pictures for the ward, to choose wallpaper and even to rearrange the patients' day. We discovered places they would like to visit on summer outings, foodstuffs they missed in the hospital menu, music they would like to hear, films they would like to see and activities and social events that would enrich their time. The patients obviously enjoyed the sessions and were anxious to come. Soon the Tuesday group was one of the high spots on their social calendar.

As the weeks went by we began to realise there were many advantageous spin-offs. The patients learned about each other and continued conversations in the day room. Staff had renewed interest in the patients, relationships deepened and conversations were more meaningful. New ideas were discovered for social activities which the patients wanted. Patients' needs were being recognised and met more than ever before. Staff morale lifted as job satisfaction increased.

Recently we started to write a summary of the group discussions, and this has provided continuity from week to week as well as a teaching tool to help learners and new staff to see beyond the old woman or man sitting in a chair. They can now appreciate some of the life events and experiences which have shaped the individual and, therefore, develop an understanding and empathetic attitude towards them.



MASLOW, an American psychologist, has described a hierarchy of needs for personal fulfilment[12].

The nursing process has provided a tool to help us meet the more basic needs of our patients, but we feel that bibliotherapy has taken us much further. No longer are we frustrated or content to remain at basic levels of care. No longer are we anxious or uncertain that the care is not patient-oriented. Now we have confidence, knowing that the ward routine, the social programme and the nursing care are organised to meet the needs of the patients.

Sweeney claims that bibliotherapy taps the capacity to experience joy in life. It restores morale by giving patients a feeling of importance, and encourages activity, providing mental gymnastics. It rekindles feelings of competence by reminding people of past skills, goals and ambitions achieved, and it provides a channel for reminiscence; joy and laughter are remembered and unresolved hurts or regrets aired. It is a tool which helps us to guide the patients and helps them to meet their need for individual self-fulfilment. ■■■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22 May 1986

Physician's Association
of
Saint Elizabeths Hospital

Comments on Mental Health Reorganization Plan
for the District of Columbia

REVISED STATEMENT

In October 1984 PL 98-621 was passed shifting the financial burden for the care of the mentally ill of the District of Columbia from the Federal Government to the District of Columbia. Most of the money devoted to the care of the District mentally ill had been provided by the Federal Government since it paid for the cost of operating the facility providing this care, that is, Saint Elizabeths Hospital. PL98-621 will result in the phasing out of this financial contribution.

The District, therefore, has been under pressure to develop a new way to care for its mentally ill with its diminishing federal financial assistance, and the mental health system reorganization office was formed to devise a plan that would attempt to meet these needs with diminished resources.

In recent years, beginning in the mid-fifties and accelerating in the late sixties through a process known as deinstitutionalization, state inpatient hospital populations of the mentally ill were reduced by over 75% in the United States. The Saint Elizabeths Hospital population reduction during this time surpassed the national average reduction. These reductions were made in part by improved methods of treating the mentally ill, and in part by social, economic, ideological and legal pressures. It was also an economic policy that made it advantageous to reduce state hospital populations because programs such as Medicare made it possible to shift financial burden of care from the states to the Federal Government. Patients were discharged to nursing homes, supervised after-care facilities, their own families or to independent living situations. This was an experiment that involved hundreds of thousands of individuals, but recent reviews of the literature show few controlled studies of patients discharged after long stays in mental hospitals. Much has been written about the process in the intervening years. Literature about the lack of care for the homeless mentally ill is becoming increasingly abundant. Reports of growing mortality amongst the elderly mentally ill transferred to nursing homes

are increasing. Articles describing the jails as our new mental health system are occurring more frequently. Anecdotal stories of tragedies of families trying to cope with a discharged, mentally ill relative are seen occasionally in the press, and occasionally sensational stories of former mental patients are featured on television documentaries and in the printed press. Some still believe that the concept of deinstitutionalization is a good one, if only the implementation was not mishandled, and if only enough resources were devoted to its proper implementation. But it is ironic that while technology to treat psychiatric patients has improved dramatically in the last 30 years, the availability of treatment to so many has been denied. The plan, as proposed, will result in a furthering of the process of deinstitutionalization of Saint Elizabeths Hospital resulting in greatly reduced patient population, hospital size and staff.

Putting aside the planners' needs to deal with the hard realities of money, or lack thereof, they have made what appear to be reasonable attempts to assess community services and consider laudable goals, including a commitment to community based care, a commitment to expand outreach to those in need, filling the gaps in services to maintain continuity in care, family focus systems and family support, a strong medical information service system, quality assurance, training, research, etc.,

As physicians we believe that a plan designed to care for ill people should be based on clinical needs of the patients to be served. But as we see it, the plan seems remote from patients. The plan perceives address and length of inpatient stay as important characteristics in determining programmatic decisions. Diagnosis and treatment goals that clinicians have for patients are not mentioned in the plan. The plan emphasizes level of care needed along functional lines rather than level of care based on clinical needs. Without the data on the patients' illnesses on the plan, it is difficult to make very specific suggestions, but it seems safe to say that these patients need highly specialized care and treatment since they have disorders that as a rule have responded poorly to less specialized treatment. Patients would be more skillfully treated in a diagnostically driven system rather

than in a system driven by address or length of stay. We can say with certainty that knowledge in psychiatry is going to grow, and treatment modalities are going to become more effective. The District is in a relatively unique position to evolve a reform of public psychiatry in the direction of enhancing the depth of knowledge that clinicians have about illnesses of the patients. We have an opportunity to stress clinical relevance in an area where address need not be stressed since it only covers 67 square miles. We do believe, however, that the separation of children, adolescents, the deaf, the forensic and the Hispanic are recommendations that are desirable.

As specialization and knowledge grow and anticipation of clinical skills grows we should look for ways in which specialization can evolve that is going to be fruitful for patients. The more homogeneous a patient population it is, that is from a clinical standpoint, the easier it is, other factors being equal, to staff such units. This is because a single action can effect many patients at once if the patients have the same clinical problems. We would therefore recommend that the plan state the diagnosis of the patients presently being served by the District of Columbia Mental Health Services Administration, the District of Columbia Alchohol and Drug Abuse Services Administration and Saint Elizabeths Hospital and that there be developed working groups around diagnostic entities to establish the current state of the art for a given illness. Illnesses and treatment needs of the patients should be described in the plan. The patients' needs for integrative psychotherapeutic, psychopharmacological and environmental structuring are important in dealing with chronic mentally ill patients but does not come through in reading the plan.

The plan speaks of the importance of the integrative approach, yet it removes from a single commission those who suffer from the largest single admission category, alchoholism. It removes those mentally ill with substance abuse, the most dangerous of the mentally ill, and leaves them in a separate commission. We believe that the Alchoholism and Drug Abuse Services Administration should be part of the commission of mental health. Anyone serving patients admitted to public psychiatric programs knows that many patients have alchoholism and other psychiatric

illnesses or have substance abuse and other psychiatric illnesses. It does not make clinical sense to have responsibility for these patients with two separate commissions, and it would be difficult to imagine that coordination between these two commissions will adequately serve these patients.

One of the major conclusions of those who have been responsible for the chronic mentally ill is the need for continuity of care and treatment. While statements are made throughout the plan on the need to coordinate, to track or to achieve continuity, the plan introduces a discontinuity not now present in the services provided by Saint Elizabeths Hospital. The plan proposes a 30 day limit as a definition of acute care leading to patients being moved organizationally to another treatment program. This is a discontinuity at a point where involuntary patients are struggling with issues of being committed. Job performance standards will be written to induce clinicians to move patients thru treatment programs as quickly as possible. Moving patients around will hinder the forming of therapeutic alliances especially important to psychiatric patients, and it will mean that patients will frequently need to readapt to new surroundings and treatment programs. This in itself can be very stressful and anti-therapeutic, especially to elderly patients. It would be preferable for a patient to join a program relevant to his or her diagnosis and to have continuous treatment from staff who specialize in these disorders. While admittedly psychiatric diagnostic abilities are less predictive of treatment needs than is true of many other medical disorders, psychiatrists' diagnostic abilities are improving, and it would be regrettable to develop a system that does not fully utilize potential for diagnosis in terms of both planning and in terms of obtaining specialized services that the patient needs. Such specialization could facilitate the continuity. Saint Elizabeths Hospital has been going in this direction, and its physicians are very aware of the need for continuity of care. Moreover, the plan should look for ways to enhance the preservation of relationships between patients and their present primary physicians.

Whether it was intended or not, the plan appears to perceive of case management as a linch-pin that is going to make the plan work.

The case manager may also be perceived as a factor in maintaining continuity of care. Case management has been a useful approach, especially in rural areas. It has been championed by the District of Columbia Mental Health Services Administration and by Saint Elizabeths Hospital for 15 years. But it would be difficult to pinpoint a success over the last 15 years. Given the lack of success for this concept, and given the concerns about its intrusiveness in the therapeutic process on one hand, and its potential to cause dependency on the other hand, we recommend that the case management approach be piloted during the transitional phase to ascertain which patients would benefit from such services, which are harmed and which are neither helped nor harmed.

Because public psychiatric services are responsible for those who have responded poorly to the usual psychiatric care and treatment, there is a need for clinical psychiatric research and training that will increase the city's capacity to develop greater knowledge about the most disabled and most dangerous psychiatric illnesses. This is also needed to learn how the psychiatrically ill can avoid becoming part of the city's homeless people. These problems are nationwide in scope and should be resolved with continued federal support of research and training.

We would like to address the use of staff and the use of Saint Elizabeths Hospital grounds. Those who have committed themselves to the care of the most disabled, chronic mentally ill of Washington at Saint Elizabeths over the years should be respected and retained. Staffing should give a priority to those with these skills and commitments so that all of these commissions will feel wanted in a system that will be responsible for the patients for whom they have treated and cared. A major resource for the mentally ill for the past 131 years in the District of Columbia has been the Saint Elizabeths Hospital grounds. Such a resource should remain available to the mentally ill and until proven that it is not desirable for those grounds to be a resource for the mentally ill it would be tragic to throw away a major resource for them. The grounds are likely to be seen in the future as a resource that the psychiatrically ill could have utilized. There are still thousands of psychiatrically ill people in the District who receive

no or very little psychiatric care. The plan is quite ambitious and optimistic about the future of the city neighborhoods to accept and support the care and treatment of the mentally ill. To obtain acceptance and support of the mentally ill in neighborhoods should be a goal. At the same time there should be a flexibility that allows alternative solutions to problems for some patients that may be overwhelming, such as housing shortages, difficulty establishing support systems in the neighborhoods, outpatients who wish to remain on Saint Elizabeths Hospital grounds, the neighborhoods' fears of the mentally ill, dangerousness that does not respond to treatment and the return to community settings for the patient who becomes repeatedly mentally ill. Thus it is an error to write off the resource of one half of Saint Elizabeths grounds prior to proof that the neighborhoods will be a satisfactory alternative. Some speak of the stigma of Saint Elizabeths and develop syllogisms based upon the idea that the stigma is permanent and universal. Thus it is argued that there should be as few services on Saint Elizabeths grounds as possible. This stigma need not be permanent, and it is not universal. Many professionals, judges, police officers, correctional officers, and most importantly, patients' relatives do not have the same negative connotation when they hear Saint Elizabeths. The west side of the grounds should remain a potential resource. We should not assume a stigma is insoluble. Non-hospital needs, asylum programs, group homes, shelter workshops, recreational programs, vocational programs, specialty clinics and long-term residential programs could all become important elements for the mental health system of the 1990's, programs that could logically be placed on the west side of the grounds. A major achievement for the psychiatrically ill occurred in the early 1850's when Dorothea Dix obtained this land for the mentally ill, and it should not be lost to them because we are going through a phase in public psychiatry that has limited respect and concern for public institutions. The implementation of the joint William A. White Division (NIMH)-Saint Elizabeths Hospital Clinic is informative. That clinic now makes considerable use of CAT scanners. On the horizon are some extremely expensive procedures that may become state of the art in the treatment of psychiatric disorders, or at least in their evaluations. Such procedures may become important

not only diagnostically, but in periodic evaluations of a patient's treatment. Economics will dictate only one locus of such approaches. Saint Elizabeths grounds are likely to be the logical choice.

ASYLUM NEEDS:

Not to mention the need for asylum is to dodge a basic fact: not all of the psychiatrically ill in the 1980's can be successfully treated to where their behavior will be acceptable in community settings. The plan should admit that some patients need an asylum and that asylum should not be in the streets. While many of the very chronically mentally ill can be managed in small group homes, others will have their greatest freedom from their illness and the consequences of their illness when they are living on the grounds of Saint Elizabeths. Restated, the recognition that some severely mentally ill need an asylum of Saint Elizabeths grounds is part of the full continuum of services that the plan calls for. The full continuum must include a full recognition of the asylum needs of the most disabled and the most dangerous patients. This in turn will help make CRFs a success by their not having to care for such patients. By having an asylum program on the grounds of Saint Elizabeths, rehabilitation programs will not be frustrated with these patients and the patients will not have to suffer of the pains of being part of rehabilitation programs that are not working for them.

PRIVATE SECTOR PATIENTS:

It is estimated that 450,000 citizens in the District of Columbia have some form of health insurance. With very few exceptions, the coverage of psychiatric services in those plans is inadequate. The plan should speak in favor of requiring adequate insurance coverage for District citizens who have mental illness. It is unconscionable for the plan to be silent on this discrimination. The Commissioner on Mental Health should regard it as his or her responsibility to pursue satisfactory mental health coverage in health insurance plans in the District of Columbia.

THE NEED TO MOVE FROM DEBATE TO DATA:

The plan frequently points out the need to move from an ideological posture to empirical information. The ideology of the 1950's has said that the mentally ill need to be kept out of institutions and placed in

communities became the shame of the streets in the last part of this century. Major ideologies, in implementing their creeds, generally concern themselves with the degree to which social policy conforms to their doctrine, rather than the actual affects of the policy on the problems it was designed to cure. Ideology is blind to the mentally ill freezing in the streets and blind to a psychotic lady pushing a bystander in front of a subway train. A basic question is what should determine the foundation of actions taken with patients, either the individual patient or patients en masse. In adopting an empirical standard, we need to identify potentially desirable outcomes for patients in measurable terms, assess whether the outcomes are attained, and if so, the cost involved in attaining those outcomes. The Office of Dr. Gladys Baxley stated the issue well in their memorandum of December 16, 1985: "Even with the best of public intentions and well designed plans, CRFs become difficult to locate, community pressures decide placement decisions, CRFs are mismanaged, budgets are cut, patients decompensate and leave community dwellings, linkages in systems that withstood theoretical tests fall empirically." We would propose that in 1986, 1987 and beyond, controversial concepts be piloted, such as:

--Contracting out for acute inpatient psychiatric treatment in general psychiatric hospitals should be piloted before expanding this concept for many. The concept also appears to contain an increase in clinical discontinuity and an increase in costs, albeit not necessarily increased costs to the District of Columbia taxpayers. The plan points out that the chronically mentally ill are to be the priority of the new system, not areas for which the psychiatry departments of general hospitals are best known. Whether proponents are correct in believing that these contracts will provide the psychiatric patient with high quality care of treatment or whether the critics are correct in saying that it will be a "21-day car wash" should be tested empirically. More specifically, we should define the patients' subgroup that would be most effectively and efficiently served by a psychiatric unit of a general hospital, rather than have an arbitrary system that says some go to the psychiatric department

of a general hospital and some go to the acute unit of the public hospital.

--Nursing homes and CRFs should be profiled, as they vary in their capacity to increase or maintain the function of psychiatrically ill patients. Just as we have the indications, cautions and contraindications for prescribing a given medication, we should have the indications, cautions and contraindications for prescribing a given nursing home or CRF. Studies have shown, that transfers from public mental hospitals to nursing homes can be lethal.

--While the increased emphasis on services to children and adolescents is extremely worthy, we need to remember that present public psychiatric services for children and adolescents are going unused. Thus, proposals to expand such services five-fold, ten-fold or even more, should be approached empirically.

In moving from debate to data, we need to clarify goals. The goal with each patient should be to attain the maximum function possible or, restated, to achieve the maximum freedom from the illness and consequences of the illness as is practical. All references in the document that suggest that the goal with patients is to get them "through the system" should be removed. Let's define the goals in terms of improvement of patients rather than a status in the system.

The physician's role and responsibility should be more defined within the plan to insure that each patient has a satisfactory psychiatric evaluation and treatment plan. This requires that there be an authoritative leadership of the Mental Health System that can speak knowledgeably about the needs of patients. From top to bottom, there needs to be a clear accountability that assures that the patient's psychiatric care and treatment is adequate. In one of the earlier proposals, the "medical director" seemed to be too much of a staff position, too much on the sidelines. There should be someone who is fully accountable for assuring that each patient's psychiatric needs are fully met. There are two approaches that would increase the psychiatric accountability. One approach would be to move the "medical director" into the Commissioner's Office and establish accountability at that level. The second proposal would be to have a

matrix organization in which there would be programmatic lines of accountability and professional lines of accountability. For example, the programmatic lines would define who would be served, circumstances of their being served, and so forth. The professional line accountability would address issues of the adequacy of the psychoparacological agents being prescribed, the adequacy of the psychotherapeutic efforts being prescribed, and so forth. While matrix organizations have the potential problems of "two bosses," in actuality many hospitals and health care organizations informally have a matrix system even though it remains unspoken. Accountability in public psychiatric organizations, especially large ones, is easily lost, and so we are recommending that the accountability be overt and formal. Restated, there needs to be clarity as to the psychiatric responsibility down to the individual patient. This means that each patient must have an evaluation by the psychiatrist and must have a treatment plan in which a qualified psychiatrist has participated.

The Commissioner should be well versed in public mental health administration and be able to speak authoritatively about the needs of the patients.

Logistically and to meet the JCAH requirements, a single medical leadership may be needed at Saint Elizabeths Hospital, as JCAH usually requires the focus of medical accountability at the Hospitals they accredit.

Some believe that "intake teams" will be wasteful. We should test out the usefulness of intake teams to clarify the circumstances in which a team is useful and under what circumstances a psychiatrist alone is satisfactory in making the initial evaluation and decision.

The plan appears to call for sufficient and greater alliance on adult acute psychiatric beds in the District's general hospitals. We are not aware that the psychiatric units of these general hospitals want to assume responsibility for the very dangerous or quite disabled patients

that constitute Saint Elizabeths admissions. The plan acknowledges that "the exact number of non-Saint Elizabeths Hospital psychiatric beds is difficult to determine" and more importantly that "private providers may lack interest or skills in treating the most destitute and chronically ill." These limitations make proper planning and evaluation critical. Even if the psychiatric units are willing, the plan appears to call for discontinuity of patients crossing back and forth between the public and private sectors. Contracting for acute inpatient psychiatric treatment should be piloted first to iron out some of the difficulties and clarify some of the questions before it is done on a massive scale. Moreover, if the private psychiatric sector is to be involved, adequate coverage for psychiatric illness needs to be assured by private insurance, Medicaid and Medicare.

To increase the responsiveness of the total system, the Emergency Psychiatric Resolution Unit (EPRU) should be given a more prominent location within the organization. This unit should be held accountable for assuring that all in the District who really need public psychiatric services have public psychiatric services, whether they have an alchoholism diagnosis, substance abuse diagnosis, or other mental illness. They should have authorities to make "must-be-honored referrals" that no one below the Commissioner could refuse. This unit has the potential of being the right arm of the Commissioner to assure that the system reaches all those very much needing psychiatric services. Furthermore, it appears that the unit will sometimes need to service those under the age of 18. This unit will be the most visible interface between major public and private agencies and individuals. As the most prominent interfacing agent of the Commission, that unit should report to the Commissioner.

The plan is to be commended on emphasizing the need for an expansion of services to youth. At the same time, these huge expansions, some of which appear to be an expansion of about ten-fold, need to be piloted to be sure that such programs will be utilized. It has been charged, for example, that the emergency psychiatric service unit, open fourteen hours a day, might have only several patients to evaluate on a given day. It may be that the initial evaluation of emergency cases would be much more efficiently handled by some child expertise within the Emergency Psychiatric Resolution Unit.

The vast increase in the sense of responsibility for the children and adolescents, a most commendable decision, would be facilitated if there were someone with considerable authority in the Mayor's Office to assure the key agencies serving children and adolescents to cooperate fully to meet the needs of the child. Even more desirable would be an office within the Mayor's Office with authority to bring about the kinds of quality and coordination that are going to be needed to facilitate the plan's commendable hopes. The District of Columbia's Mental Health Services Administration estimates that there are 73 services in the city for children and adolescents. The plan will increase that even further. An office with considerable authority to bring corrections, schools, and Department of Human Services non-mental components is needed to well serve children and adolescents. We suspect that the liasons proposed will frequently not be able to obtain the collaboration and cooperation that the most seriously ill child or adolescent needs.

Saint Elizabeths Hospital now has a personnel system that is responsible to the Superintendent. Removing such services from the Commission on Mental Health and placing them at a higher level is a setback for the clinical leadership of the new system. The proposal to add staff to the District's present personnel office rather, than delegating authorities to the Commission on Mental Health that would parallel the authorities that the Superintendent of Saint Elizabeths Hospital now has, will lead to a less responsive staffing of mental health programs that thousands of patients now being served by Saint Elizabeths have.

Removal of the budgetary authorities that the Superintendent now has and placing them outside of the Commission on Mental Health will reduce the budgetary flexibility and responsiveness that programs now serving Saint Elizabeths patients have.

The association regrets that it cannot make any meaningful response concerning the staffing patterns as proposed. Judging by the numbers given, it does not seem likely that many physicians will be losing jobs, but the numbers given seem to be predicated on receipt of funds for the system which are by no means assured. No physician has assurance that he or she will have a position under the new system.

Positions are fractionalized and assigned along organizational lines unfamiliar to our physicians. Physicians do not know whether their particular expertise will be needed in the new system. It is not known how Residents are counted in this new system or whether new positions will be filled in the District which will substract from positions available to Saint Elizabeths physicians prior to the transfer. There is some concern also that the physician comparability allowance will not be continued beyond the present contract. It is disconcerting that more specific information has not yet been forthcoming so that each physician can make his or her own career plans.

Training. The Physicians Association of Saint Elizabeths Hospital supports Mayor Barry's request for Congressional support of training. There is a need for full Congressional support of Training. In Public Law 98-621 Congress wisely called for continued Federal support of training (2)(b)(6). Training Saint Elizabeths has been a Federal magnet that has attracted quality staff, has attracted minority trainees in unusually large numbers, and has attracted people who have become Hospital, local and national mental health leaders. Federally supported training has been a conduit and a catalysis of current and innovative treatments for the mentally ill. Saint Elizabeths training programs have enhanced the knowledge and skill of every clinician who serves any of the Hospital's patients. Relative to innovative approaches, training assisted Saint Elizabeths in establishing new psychotherapeutic treatments in the 1940s, in understanding new psychopharmacological therapies in the 1950s, in developing community psychiatric programs in the 1960s, in comprehending new diagnostic entities in the 1970s, and in exploring outreach psychiatric services to the homeless in the 1980s. This federal legacy has been a key element in Saint Elizabeths' sense of pride and worth over the decades. At

a cost of only five million annually, this Federal legacy can continue as an expression of Congress' wish that the Nation Capital's most dangerous, most disturbed and most disabled mentally ill receive quality services.

Hypothesis and Moratorium. In general the Reorganization Office has had an admirable planning process culling the thinking of local and national mental health authorities to propose a plan to expand the reach of effective and humane care and treatment of the psychiatrically ill. Despite the problems we have stated, there is much to admire. Whether the Plan will provide the effective and humane care and treatment envision is hypothetical, however. Until it is a fact, not a hypothesis, that the West Side of the grounds is not needed, there should be a moratorium on planning the use of the West Side of the grounds. By 1989 or so, if the planning stays on schedule, we should know the degree to which the West Side will be needed, if at all, in assuring that there is a full range of opportunities that the mentally ill will need.

Final Note. As the Physicians Association of Saint Elizabeths, we want to remind the reader that the planning that emphasizes the need for alternative to hospital care and treatment can leave us forgetful of the role of Saint Elizabeths Hospital as a resource for the care and treatment of severe mental illnesses. It is not a warehouse restricting the movements of socially undesirable.

Increased understanding of the complexities of mental illness, technological advances, new and move effective methods of diagnoses and treatment demand a well equipped, well staffed facility as Saint Elizabeths has been and can again become. We should remember that while the rhetoric about "deinstitutionalization of the poor has been emphasized for two decades, the use of hospitals by the middle and upper classes has grown remarkably because of the growth of what hospitals have to offer the psychiatrically ill.

While the emphasis in the treatment of the psychiatrically ill is on care rather than on cure, we should not dissuade from providing this care, because of priorities which preclude the use of funds to care for people whose illnesses happen to affect the brain rather than some other organ of the body.

Signed,

Henry A. Skopek, M.D. President

Mr. BARNES. Mr. Fauntroy wants to thank each one of you for providing the subcommittee with an excellent oversight of the progress being made toward implementation of Public Law 98-621.

We have come a long way, and we have a long way to go. If we continue to work together to bring about our desired goal, the citizens of the District of Columbia will be the better for it.

Mr. Fauntroy wishes to urge each of you to continue to seek the very best possible way by which we can do just that.

With that, the subcommittee stands adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

# APPENDIX

# MSDC

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

2007 Eye Street, N.W.
Washington, D.C. 20006
(202) 466-1800

Massimo A. Righini, M.D., President
P. Douglas Torrence, Sr., Executive Director

Statement of
Medical Society of the District of Columbia

To the
Congressional Committee on the District of Columbia
Subcommittee on Fiscal Affairs and Health

Oversight hearing on PL 98-621
St. Elizabeth's/District of Columbia
Mental Health Services Act

May 21, 1986

The Medical Society of the District of Columbia -- a state medical society of 3,600 physician members practicing in or near the District of Columbia --- is pleased to submit the following recommendations regarding the Mental Health Implementation Plan, proposed by the District of Columbia Mental Health Reorganization Office.

1. The role of the physician needs to be more explicitly delineated. The psychiatric evaluation, diagnosis and treatment plans for patients must be clearly stated. Accountability for psychiatric treatment must be clearly defined. Explicit plans must be made for treating any other illnesses these patients may contract.

   The position of medical director seems to be more advisory than tied directly to the line of care for these patients. No mention is made of a medical director for each of the three Administrative sections. The medical director's position needs to be present in all three sections and its responsibilities specified. The Commissioner's qualifications are not specified. Charged with overall responsibility for the care of these patients, this person should be a psychiatrist.

2. It is important that psychiatric training be retained. These programs are a major source of public psychiatric staff and an alternative for psychiatrists who wish to work in the public sector and contribute to the knowledge and skills of clinicians in the public sector. This training program is unique, and many minority physicians have been able to train there. The Congress called for federal support for the

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training program in the transfer legislation. We call upon Congress to support that intent by providing adequate federal funding. If federal funding is withdrawn, then funds for training psychiatrists must come from District sources. Discontinuing the training program would ensure the loss of a valuable resource for this community.

3. We commend the proposed reduction in beds and shift to community facilities; however, we know that the ideal is not often realized. This shift should be carried out slowly to ensure that we don't relinquish sources before their substitutes become available -- if they become available. Also, providing asylum beds, though unpopular at this time, is a proposal that must be considered.

   In the report, Washington's small size is referred to as a benefit in that it would allow consolidation of services which larger areas would find impossible. At the same time there is a focus on decentralization to neighborhood resources. This may be an ideal but we also should be aware that such receptive and organized neighborhood facilities often do not exist.

4. The District of Columbia Mental Health System and the Commissioner of Mental Health are in part justified in bringing the treatment of the mentally ill under one agency. However, some of the biggest sources of mental patients remain outside of this jurisdiction. Facilities for the treatment of alcohol and drug abuse should be included in the plan to ensure continuity of care, reduce confusion and prevent a split in authority. Some of the same thinking might be applied to the care of the mentally retarded.

5. The implementation plans contain many laudable aspects. We are concerned, however, that these wonderful plans not end up as "pie in the sky." How solid is the funding? Is it sensible to watch the federal government withdraw support and yet expect it to help fund our community hospital endeavor through Medicaid?

   Any comprehensive plan for the mentally ill in the District should address the issue of adequate mental health benefits in District health insurance policies. It is estimated that about 70 percent of District residents have some health insurance and virtually all health insurance plans discriminate against the mentally ill. This discrimination against the mentally ill must be abolished. If this were accomplished, we could reduce the number of people requiring publicly supported care.

6. The fate of the Westside of St. Elizabeth's Hospital is not discussed in this report. It may be more efficient to concentrate the hospital's functions on the Eastside. Dorothea Dix, over 130 years ago, obtained this land for care of the mentally ill. The Westside property should remain in the Mental Health Care System to benefit mental patients in the D.C. area, whether or not patients are actually housed there.

June 9, 1986

The Honorable Otis R. Bowen
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Mr. Secretary:

On Thursday, May 22, 1986, The Subcommittee on Fiscal Affairs and Health of the Committee on the District of Columbia held oversight hearings on the preliminary plan to implement P.L. 98-621, "The Saint Elizabeths and District of Columbia Mental Health Services Act". In response to questions asked during the course of the hearing, Federal and local officials as well as those witnesses representing professional and labor associations raised serious doubts regarding the future of the plan should there be any further decrease in the Federal funding as anticipated in P.L. 98-621.

During the course of the legislative negotiations, in 1984, a good faith agreement was reached between the Federal government, the government of the District of Columbia and the Congress regarding direct payments to the hospital and the special supplement as authorized in Section 9 (2)(b)(1). This good faith agreement came as the result of a compromise in anticipation of deficit reduction actions by Congress and the Federal government. While it is not my intention to quarrel with the merits of Gramm-Rudman-Hollings, the impact of any further cuts in the funding of St. Elizabeths Hospital would have a double jeopardy effect and therefore would be a breech of the 1984 good faith agreement.

In the long run, the removal of St. Elizabeths Hospital from the Federal roles is a wise and cost effective action. But it cannot be done as outlined in P.L. 98-621 unless the Congress and the Federal government work cooperatively toward that end.

Sincerely,

RONALD V. DELLUMS
Chairman

RCW:lmw

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 18 1986

The Honorable Ronald V. Dellums
Chairman, Committee on the District
of Columbia
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This is to acknowledge receipt of your letter of June 9, 1986, expressing concern about additional cuts in the funding of St. Elizabeths Hospital, as anticipated by implementation of P.L. 98-621, "The Saint Elizabeths and District of Columbia Mental Health Services Act."

I have asked my staff to prepare a response for my signature as soon as possible.

Thank you for bringing this matter to my attention.

Sincerely,

Otis R. Bowen, M.D.
Secretary

RECEIVED
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Committee on the District of Columbia

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TELEPHONE: 225-4457

U.S. House of Representatives
Committee on the District of Columbia
ESTABLISHED 27 JANUARY 1999
Room 1310, Longworth House Office Building
Washington, DC 20515

June 9, 1986

The Honorable Marion S. Barry, Jr.
Mayor of the District of Columbia
1350 Pennsylvania Avenue, N.W.
5th Floor
Washington, D.C. 20004

Dear Mr. Mayor:

In accordance with Section 5 (a) of P.L. 98-621, the Saint Elizabeths and District of Columbia Mental Health Services Act, the Subcommittee on Fiscal Affairs and Health of the Committee on the District of Columbia held oversight hearings on May 22, 1986, to determine the extent to which the preliminary transfer reorganization plan complies with the intent of Congress as expressed in Sections 2 (b) and 4 of P.L. 98-621. The Committee considers certain areas to be of such importance as to warrant being brought to your attention.

First, the Committee commends you and the Mental Health System Reorganization Office staff for undertaking and delivering, on time, a preliminary plan which complies with both the intent and letter of P.L. 98-621. The spirit of cooperation shown by Ms. Virginia Fleming has enabled Committee staff to have available a constant flow of pertinent information. I am sure this close cooperation will continue throughout the entire process. I applaud Ms. Fleming for her extraordinary work on this project.

In preparation for the hearing, witnesses were asked to pay particular attention to their areas of concern and to bring to the Committee what in effect was "the worst case scenario". Therefore the following staff memorandum is forwarded to you to assist in your review of the status of the reorganization and is not intended to be interpreted as being critical of the plan or the Mental Health System Reorganization Office staff.

In closing, let me assure you of our continued support of your efforts to bring about a timely and orderly process in implementing P.L. 98-621. Your concerns regarding the Federal role in funding at the levels mandated by P.L. 98-621 and the need to bring the infrastructure of St. Elizabeths Hospital into compliance with all pertinent standards and accreditations is being forwarded to the appropriate House and Senate Committees as well as Health and Human Services Secretary, Dr. Otis Bowen.



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Please continue to keep the Committee informed of any changes which may adversely effect the completion of the plan in a timely manner.

Sincerely,

WALTER E. FAUNTROY
Chairman
Subcommittee on Fiscal
Affairs and Health

Enclosure

June 10, 1986

STAFF MEMORANDUM REGARDING P.L. 98-621, THE SAINT ELIZABETHS AND DISTRICT OF COLUMBIA MENTAL HEALTH SERVICES ACT

On April 29, 1986, the Subcommittee on Fiscal Affairs and Health held oversight hearings into the events and circumstances surrounding the death of Mr. Emory Lee. Mr. Lee died while in a seclusion room on Ward 10, Dix Building, St. Elizabeths Hospital. Mr. Lee was diagnosed as having Downs Syndrome, profound retardation, seizure disorders, and as having a secondary diagnosis of a psychiatric nature. He was a dual diagnosed patient.

Among those testifying before the Subcommittee on May 22, 1986, was Mrs. Polly Shackleton (Ward-3) and Chairperson, City Council Committee on Human Services. Mrs. Shackleton paid particular attention to the need of a specialized program for dual diagnosed patients such as Mr. Lee. According to Mrs. Shackleton, a special task force has been created by the Mental Health Services Reorganization office to develop an appropriate means whereby this unique population can be served. The Subcommittee urges that this program be given the priority status necessary to insure its success as a part of the overall Mental Health System.

Of particular concern to the American Psychiatric Association and the American Association for the Advancement of Psychology, is the support system needed to provide the highest level of community based care. Both organizations expressed concern as to the lack of clarity in the preliminary plan with regards to the continued presence of professional staff as central to patient care. The Subcommittee acknowledges some professional competition between the American Psychiatric Association and the American Association for the Advancement of Psychology; however, it is urged that the Mental Health System Reorganization Office staff look very carefully at the patient/staff ratio throughout the plan and to make those adjustments necessary to insure the same level of quality care is maintained in the future as is now found at St. Elizabeths Hospital. It is also recommended that a series of educational seminars begin that would allow for an airing of professional concerns by the American Psychiatric Association and the American Association for the Advancement of Psychology members now on staff at St. Elizabeths Hospital. Many of the fears regarding the direction the new system will take can be addressed and satisfied by such a series of meetings.

The representative from A.F.S.C.M.E. expressed concern regarding "conditions of employment for those workers who accept a job with a private contractor". They suggest that, "the city include minimum standards in all requests for proposals from private contractors to insure that benefits enjoyed while employed at St. Elizabeths Hospital are maintained by the private contractor". Also, A.F.S.C.M.E. is concerned about training and re-training of former St. Elizabeths Hospital workers who are brought into the new system.

During the course of the legislative negotiation in 1984, representatives of the Mental Health Law Project and Dixon Implementation Monitoring Committee played key roles in assisting the Committee in framing the patient care portion of P.L. 98-621. In light of this, the Committee paid particular attention to their criticism and recommendations. Included is their complete statement for review. Some of their recommended changes are sound and should be given further consideration by the Mental Health System Reorganization Office. Others may fall in the category of being outside the realm of cost effectiveness.

Two areas of concern were expressed by a majority of the witnesses. They were, mental health services for the expanding population of the homeless and the inclusion in the system of the alcohol and drug abuse programs. Both areas have political and substantive questions which need to be addressed in greater detail than is now presented in the preliminary plan. While the Subcommittee is not dissatisfied with the direction suggested in the plan, it is felt that both areas need to be explored in greater detail.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
National Institute of Mental Health
Rockville MD 20857

The Honorable Walter E. Fauntroy
Chairman, Subcommittee on Fiscal Affairs
and Health
Committee on the District of Columbia
House of Representatives
Washington, D.C. 20515

Dear Mr. Fauntroy:

This is to request that the transcript of the May 22, 1986, hearing before the Subcommittee on Fiscal Affairs and Health of the Committee on the District of Columbia accurately reflect verbal testimony given by Mr. Norman Rosenberg, Director, Mental Health Law Project.

The accuracy of the transcript and record is of vital importance in light of the enclosed article from The Washington Times of May 23, 1986, regarding criticism of the District's Preliminary System Implementation Plan by Dr. Leonard Stein and attorney Norman Rosenberg of the Mental Health Law Project. Although the newspaper article indicated that Dixon plaintiffs were considering requesting a special master over St. Elizabeths Hospital, this is not true. A motion is pending before the U.S. District Court for the District of Columbia for appointment of a special master over the District's mental health system. Federal defendants including St. Elizabeths Hospital have been, and remain, in compliance with the court decree.

Apparently the newspaper report is based on the written statement of Mr. Rosenberg which was available at the hearing, stating that the Dixon plaintiffs were considering appointment of a special master to "operate the hospital and the community service system." However, Mr. Rosenberg's oral testimony made no mention of the hospital. Mr. Rosenberg and Mr. Joseph Manas, the Mental Health Law Project's legislative official, were questioned regarding the difference in the oral and written statements. Both confirmed that the written statement was in error and no plans were being considered for court action against the hospital, only against the District of Columbia. We further recommend that you solicit a written correction to the Mental Health Law Project's written statement for inclusion in the committee report.

Your assistance in this matter is greatly appreciated.

Sincerely yours,

Shervert H. Frazier, M.D.
Director

Enclosure

# Plan to shift St. Elizabeths to D.C. control is faulted

By Amy Stromberg
THE WASHINGTON TIMES

Citing vagueness, misplaced priorities and an underestimation of the number of people who will need treatment, a member of a group monitoring District mental health services yesterday told a congressional panel that the plan to transfer St. Elizabeths Hospital from federal to local control is seriously flawed.

Dr. Leonard I. Stein, a professor of psychiatry at the University of Wisconsin medical school, told the House District subcommittee on Fiscal Affairs and Health that not only the plan but also the city's present state of mental health care have major deficiencies.

"Nothing we have seen convinces us that the same major deficiencies we have repeatedly identified in the District's current mental health plan ... will be corrected or avoided after" the transfer, said Dr. Stein, who has monitored St. Elizabeths for five years.

The hospital, now controlled by the federal government, will be transferred to the District in October 1987 under an ambitious but controversial plan modeled after a national trend. The plan includes releasing mentally ill people into the community to care for themselves. The sprawling hospital — on a 300-acre site in Southeast — now serves 1,600 inpatients, but would be reduced by half in its size and its number of patients.

"This plan is seriously flawed," said Dr. Stein. He said the plan is lacking in services for the mentally ill who are homeless and in support structures that ensure that discharged patients can survive in the community.

Dr. Stein said the District's office in charge of designing the transfer plan "consistently resisted our efforts to help in the reorganization."

But Virginia Fleming, director of the city's Mental Health System Reorganization Office, disputed Dr. Stein's charges.

"I disagree with the notion that we have rejected them," she said after the hearing. Mrs. Fleming said the mental health monitoring committee and her office had open lines of communication. "They are official members" of the committee that worked on the plan, she said.

"The final plan will be more specific. They [the monitoring committee] are always very combative," Mrs. Fleming said.

Dr. Stein and attorney Norman Rosenberg said yesterday they may ask a federal judge to appoint a special master to oversee St. Elizabeths, claiming conditions there have not been improved in years.

They also said they would ask that the city be found in contempt of court for failing to provide — as ordered by a judge — adequate outpatient care for released mental patients. U.S. District Judge Aubrey Robinson ordered the District to provide community-based care for discharged patients.

"Unless the District begins immediately correcting the glaring and continuing deficiencies in its current provision of mental health care ... we intend to return to court with our evidence," Mr. Rosenberg said.

Mr. Rosenberg was the plaintiff's attorney in the Dixon vs. Harris case in 1980. He also is chairman of the District's Mental Health Law Project that filed the lawsuit after a National Institute of Mental Health study reported that many people were hospitalized unnecessarily.

Mr. Rosenberg said the proposed spending level of $162 million for implementation of the new comprehensive plan between 1988 and 1991 was unrealistically low for the planning goals outlined.

"I think the plan includes more money, more resources than just about any other area of the country," Mrs. Fleming said.

District Councilwoman Polly Shackleton told the subcommittee that the transfer plan could not succeed if the federal government continues to withdraw funds from the hospital.

St. Elizabeths officials said $4 million in reductions in federal funds due to the Gramm-Rudman deficit reduction legislation this year has the potential to affect patient care negatively.

William J. Forbush, deputy assistant of health operations, said equipment, supplies and certain services have been cut. "But patient care has not been adversely affected yet," he said.

DISTRICT OF COLUMBIA

MENTAL HEALTH SYSTEM

# EXECUTIVE SUMMARY

# PRELIMINARY SYSTEM IMPLEMENTATION PLAN

January 1, 1986

Government of the District of Columbia • Marion Barry, Jr., Mayor

# EXECUTIVE SUMMARY

# PRELIMINARY MENTAL HEALTH SYSTEM IMPLEMENTATION PLAN

District of Columbia Government

January 1, 1986

Marion Barry, Jr.,

Mayor

## PREFACE

The District and Federal governments have been jointly responsible for providing mental health services to the residents of Washington, D.C. for more than a century through Saint Elizabeths Hospital and the District's mental health services. During most of this time, the hospital has dominated the service system. Only in the last few decades has the emphasis on where and how mental health services should be provided begun to change.

After many years of debate about transferring the federal hospital to local authority, the Congress of the United States passed Public Law 98-621, the "Saint Elizabeths Hospital and District of Columbia Mental Health Services Act" in 1984. It became effective on October 1, 1985. This law defines the way in which federal management and support of its national mental hospital will end and the District of Columbia will assume responsibility for its own comprehensive mental health system.

The law sets forth in detail how the District government will take over responsibility for the major functions, programs and resources of Saint Elizabeths Hospital. It contains provisions for standards of mental health care, establishes protections for the federal employees at Saint Elizabeths Hospital and authorizes funds for the costs of transition.

P. L. 98-621 establishes a six year transition period from its effective date of the law, October 1, 1985, to October 1, 1991. A critical milestone during the transition is set at **October 1, 1987**; on that date, the District government assumes full responsibility for patient care and federal management of the hospital ends. By **1991**, the District government will have in place all the components of its comprehensive mental health system. Direct federal appropriations to the hospital and the annual transition payments will end on October 1, 1991.

The law also spells out a process for legislative review of the District's plan to develop an integrated mental health system. This Preliminary System Implementation Plan is submitted to the Council of the District of Columbia in fulfillment of the first step in this process. Following Council review and comment, the Mayor will forward the Preliminary Plan to the United States Congress on April 1, 1986. Following Congressional comment, the Mayor will develop the Final System Implementation Plan and forward it to the District Council on October 1, 1986 as a formal reorganization plan on which the Council acts to establish the new system within the District government. From January to March of 1987, the Congress has an additional opportunity to comment on the plan prior to the assumption of District responsibility on October 1, 1987. Implementation of the system will take place on October 1, 1987.

Mayor Barry established the responsibility for implementing the legislation in a new Mental Health System Reorganization Office (MHSRO) under the supervision of the Director of the Department of Human Services. MHSRO has for the last ten months conducted a broad planning process resulting in a draft Preliminary Plan.

That plan was circulated by the Mental Health System Reorganization Office to encourage widespread public review and comment prior to this submission of the plan to the Council.

The State Mental Health Advisory Council conducted a conference to discuss this draft plan on November 14 and 15, 1985. MHSRO conducted public hearings on November 20 and 21, 1985, to receive comments. Written comments were also encouraged.

This plan reflects the hopes and concerns expressed by nearly 800 patients receiving mental health care in the District who met in small groups with MHSRO throughout 1985. It further reflects the thoughtful work of nearly 400 consumer advocates, providers, professionals and citizens who participated in groups which addressed many different aspects of the plan. The planning process greatly benefited from the counsel of many mental health practitioners in other states and cities who shared their experience and views with staff and working groups. The process was enhanced by the participation of other District public agency officials, many of whose programs must be closely integrated with the new mental health system. Finally, the document is the product of the dedicated efforts of the staff of MHSRO, whose hard work and commitment produced the plan within the demanding timetable established by the Congress. All of these persons are acknowledged, with deep appreciation, on the following pages.

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## INTRODUCTION

The new comprehensive mental health system in the District of Columbia will move beyond the model developed by comprehensive mental health centers over the past 20 years and create a system that unifies all services -- inpatient, outpatient, psychosocial rehabilitation, day hospital, supported and supervised residential programs and medical and clinical supports -- into an integrated system of care for each patient.

Implementation of the plan will be the responsibility of a new Commission on Mental Health to be established in the Department of Human Services. The Commission will absorb into a single authority the functions of both the District's Mental Health Services Administration and of Saint Elizabeths Hospital and mold them into a new, vibrant system.

This plan builds upon the tremendous advances in mental health care that have been made over the past several decades, advances that are reflected primarily in research findings, professional training and the experience of community mental health programs. At the same time, the new system will put policy and resources in place to overcome two major national shortcomings in community mental health: inadequate follow-up care for people with chronic mental illness living outside of institutions and inadequate attention to the needs of children and youth.

With this reorganization, the District joins with those localities in the nation struggling to create a workable system of mental health care. The District of Columbia has a unique opportunity, however, to structure a total system of care because of some special advantages.

First of all, our government combines city, county and state functions. The jurisdictional barriers and multiple funding sources that in other places work against a coherent system can be overcome. For example, mental hospitals are usually under state authority and outpatient services under county or city authority. In the District, all services can be unified under a single

authority. The District is also of manageable size, small enough, with its population of about 630,000 people and an area of 68 square miles, to make possible central administration and policy direction. Perhaps most important, this city contains a pool of mental health talent and resources of extraordinary richness and diversity.

The plan that will bring about a new system is based on the premise that mental illness is treatable, that while most people who are mentally ill are being treated they can continue to be (or soon return to being) productive members of our community and that while in treatment they deserve the best care available. The plan is also based on the premise that most mentally ill people are capable of -- and should be -- partners in the design and development of their own treatment plans.

The aim of the system will be to ensure high quality mental health treatment to all who seek it. Explicit interagency agreements will ensure that people in the mental health system get the additional services they need -- such as assistance in finding appropriate housing -- from other city agencies. Such agreements will also ensure that mental health care is available to people in other settings, such as nursing homes, juvenile institutions or shelters.

The new mental health system will ensure that all patients have access to psychiatric and psychological assessment and treatment, as well as to supportive psychosocial, therapeutic and medical services as an integral part of the process. By making available a range of treatment and support programs, this system will help individuals progress toward recovery and successful independent living.

The new mental health system will be based on a commitment to community-based care. The effectiveness of noninstitutional care has been demonstrated in the lives of thousands of individuals now living successfully in the community. During the transition period, the unified system will complete the shift away from hospital care required by the 1975 Dixon deinstitutionalization decree which mandated mental health services in the least restrictive setting. Even today, 85 percent of the 3,700 employees and $150-million budget devoted to mental health care is allocated to Saint Elizabeths Hospital. This imbalance will be corrected during the transition period.

Treatment and hospital admission will be authorized and monitored outside the hospital by community-based psychiatrists and psychologists responsible for the ongoing care and recovery of the patient. By appropriating to the community mental health program the dollars necessary to pay for the full care of each individual -- whether inpatient or outpatient care -- the system brings together the clinical and financial incentives for continuity of care and quality care in the right setting for each person's needs.

Reducing institutional care will produce a more effective and economical system. It will permit investment in better community programs: a range of new services for children and youth, more intensive day programs for chronically ill adults, more services to the homeless, better evaluations for the courts and more effective mental health programs in the jail and prison. Another important shift is to greater emphasis on family focused services, including support for families caring for a seriously ill member.

By integrating its role as both insurer and provider, the District government will have a system of mental health care which meets the standards of care available to those with the means to pay. Under the new plan, the government can create a single-class system of care. The new system will seek to increase the amount of short-term acute psychiatric inpatient care provided by general hospitals to public patients. It will also pursue different ways to ensure that poor or uninsured persons will have appropriate care available to them, such as agreements for full "per capita" responsibility for specified individuals by medical groups or health maintenance organizations. Use of both public and private services will provide a reference for comparing quality and cost effectiveness of treatment. By involving the private sector in the public mental health system, there will be more flexibility to respond successfully to fluctuations in demand for services.

The new system will have the capacity to make sure that all persons served receive treatment and care that is sensitive and responsive to their racial and cultural backgrounds. It will also have programs to serve mentally ill people with limited English-speaking ability and those who are handicapped by disabilities such as deafness, mental retardation or physical impairments.

This reorganization plan is based on continuation of the present statutory standard for hospital commitment in the District. At the same time, it puts in place new approaches to those troubled and sometimes homeless people who seem to need mental health services but who are reluctant to receive help. Both hospital and outpatient services will be readily available for those who need them, just as they will be carefully monitored to ensure that people progress toward recovery and do not get trapped in institutional dependency. A variety of outreach techniques to identify barriers to service and to test ways to overcome them will be implemented and empirically tested.

The center of the system will be a new Commission on Mental Health to be established within the Department of Human Services. The service delivery system itself will be fundamentally restructured to centralize services for three groups of people: children and youth, adults and mentally ill offenders. Within the administrations responsible for each of these groups, programs will be designed to link the services called for in each patient's treatment plan. The long-term hospital will be reorganized into functional treatment programs, and new levels of intensive day treatment and supported residential programs will be established to create an effective continuum of care.

To resolve the longstanding problem of persons now being treated at Saint Elizabeths Hospital who are ready for a different level of treatment or care, a new nursing home and a new program for combined mental retardation/mental illness treatment will be established on the campus. More than 300 additional persons at Saint Elizabeths, and many others in the community, will be assisted in finding supervised or supported housing, including transition residential programs on the campus.

To create a more efficient system and direct more dollars toward patient care programs, mental health facilities at Saint Elizabeths Hospital will be consolidated on the east side of the hospital's existing grounds.

Orientation programs for those working in other agencies will help them understand the new mental health care delivery system, what their agency's responsibilities to mentally ill persons will be and how they can help make this new program become a success. In the first years of the transition, a great deal of effort will be devoted to helping those people already working in the system to refocus on the goals and ambitions of the new plan.

## CURRENT SERVICES

Saint Elizabeths Hospital's present range of services is comprehensive, including outpatient care, both civil and forensic inpatient care, special services for children, youth and deaf individuals, plus a research unit and a training program. The hospital has most of the ancillary services necessary to make it a freestanding entity.

The District's Mental Health Services Administration operates two main facilities, the North Community Mental Health Center, with satellites at the P Street Clinic and the Rose and Robeson Schools, and the South Community Mental Health Center on the grounds of D.C. General Hospital, with a crisis response unit. The forensic division conducts court required evaluations and administers a 24-bed inpatient unit next to the jail.

The North and South CMHCs are responsible for providing services to two-thirds of the city's population while the third segment is served by the federal Area D CMHC located on the grounds of Saint Elizabeths Hospital. Four clinical divisions of the hospital also provide treatment on an outpatient basis to some of their former inpatients who are on convalescent leave.

There are nearly 4,000 active adult outpatients receiving care from public facilities at any given time -- about 1,800 under the care of the South and North Centers, and another 2,200 receiving care from Saint Elizabeths Hospital outpatient services. About 1,000 children and youth receive outpatient services annually from North and South Centers and Saint Elizabeths Hospital. Outpatient services also are provided by private agencies and practitioners in the District.

Nearly all publicly supported inpatient mental health services in the District are provided at Saint Elizabeths Hospital, which at the end of 1984 had a resident population of 1,609 patients and over 3,344 employees. The inpatient population at Saint Elizabeths Hospital is categorized as long term for which there are 1,027 beds; acute care, (less than 30 days) 176 beds; child/adolescent care, 32 beds; forensic, 372 beds; research, 30 beds; and, deaf individuals, 30 beds.

In addition to the psychiatric beds at Saint Elizabeths Hospital, there are 611 acute care psychiatric beds in the District. Seven private general hospitals in the District have psychiatric wards, there is one private psychiatric hospital, and the Veterans Administration has over three dozen psychiatric beds occupied by District residents. Approximately 40 of those 611 beds are funded with Medicaid dollars. The total number of publicly funded psychiatric beds in the District is 280 beds per 100,000 residents, or about five times the ratio in other urban areas.

Neither the District nor Saint Elizabeths Hospital manages group homes nor contracts for their management. Most such facilities, called community residential facilities or CRFs, are privately owned and operated. Room and board is paid directly by the patient, often with stipends they receive from the federal Supplemental Security Income program or the District's General Public Assistance program. There are 203 CRFs in the District whose operators are trained to serve mentally ill adults. Residential services for children/youth currently are not provided by the public mental health system.

Forensic services are delivered by both the Mental Health Services Administration and Saint Elizabeths Hospital. Examinations ordered by the court help judges make informed decisions about an individual's competency to stand trial, criminal responsibility at the time of the crime and decisions regarding sentencing, parole and probation. Inpatient evaluations are conducted by the District at the Ugast center next to the jail and by Saint Elizabeths Hospital at the John Howard Pavilion. Three-quarters of the 370 patients living in the Pavilion were found not guilty by reason of insanity and stay in the Pavilion an average of 4.5 years.

Mentally ill persons also receive services from related District agencies, including the Commission on Social Services, Commission on Public Health, the D.C. Public Schools, the D.C. Superior Court and the Department of Housing and Community Development.

## DEFINING WHO WILL BE SERVED AND HOW MANY

Based on surveys in other cities and states, there may be as many as 98,000 adults in the District who will have some degree of mental disorder at some point in their lives and nearly 17,000 children who need mental health intervention. The public mental health system will give priority to children/youth and their families and to those who are chronically mentally ill, usually with schizophrenia and schizophreniform disorders, major affective disorders or severe cognitive impairments.

Within an adult population of 495,000, there may be as many as 30,000 who have a chronic mental illness. There are perhaps as many as 15,000 chronically mentally ill persons receiving services through public and private mental health providers and in nursing homes. In addition, an unknown number of individuals are being served by general practitioners, military hospitals, private agencies and in self-help groups. During the transition period, an important task will be to evaluate more precisely the extent to which the apparent unmet need for mental health services is being met by other resources. One important target group is those who are not insured and are not eligible for Medicaid or Medicare.

The new program establishes as a planning target that by 1991 the public mental health system will have the capacity to provide or ensure services for 10,000 adults with serious mental illness, or 1.6 percent of the population. The system will continue to serve an additional 5,000 persons each year who need short-term treatment or referral. Services to children and youth will increase from the current 1,300 served annually to about 6,700 by 1991.

## THE NEW COMPREHENSIVE MENTAL HEALTH SYSTEM

Implementation of the comprehensive mental health system will be the responsibility of a new Commission on Mental Health to be established in the Department of Human Services. Exhibit 1 illustrates the table of organization.

In accordance with P. L. 98-621, the six-year transition period will have two phases:

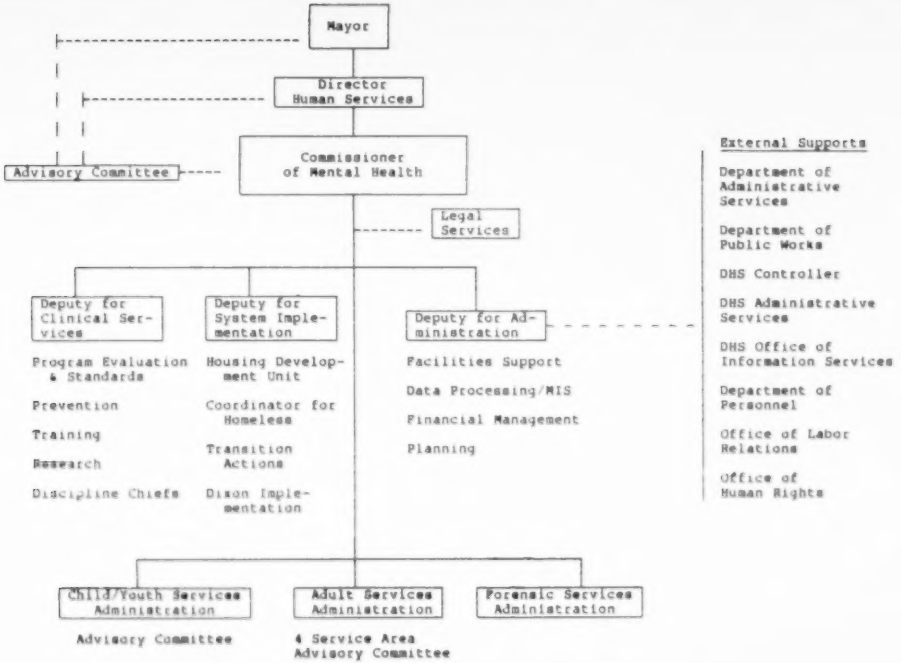
> During fiscal years 1986 and 1987 consolidation of programs and initial implementation of the plan will take place under joint District and federal management. On October 1, 1987, the District government will assume full responsibility for patient care and system management. On that date, all staff, facilities and resources identified in this plan will come under District authority.
>
> From FY 1988 until FY 1991, the District government will complete the development of a comprehensive mental health system.

Public mental health employees in the Department will increase from 300 in the present Mental Health Services Administration to about 2,300 as employees and functions from Saint Elizabeths Hospital are incorporated. The District's mental health budget will increase from about $20 million in operating programs and a payment of about $60 million to the federal hospital to a total operating budget over $130 million.

Other District departments -- particularly the Department of Public Works, Department of Administrative Services and Office of Personnel -- will require increased budgets and will incorporate some current Saint Elizabeths Hospital staff to maintain facilities and support the new mental health system.

Exhibit 1

Table of Organization
District of Columbia Mental Health System



The new design for mental health services will be organized around three principal groups of individuals who suffer from mental illness: children and youth and their families, adults who are chronically mentally ill and their families and individuals who have been charged with breaking the law and who are mentally ill.

## Children and Youth

Services to children and youth will receive an immediate increase in resources. They have often been neglected in the package of mental health programs, and substantial inroads into the population of children and youth with mental illness may reduce the need for mental health services to them in years to come.

The public mental health system currently serves about 1,300 children and youth annually. The planning target for the new system is to have the capacity to serve 2,200 children/youth and their families a year by FY 1988, and some 6,700 a year, by 1991.

In the new system, these services will be centralized in a Child/Youth Services Administration so as to have a single locus of accountability, continuity and integration among the various service components. Exhibit 2 illustrates the table of organization. This new structure parallels other systems in the city providing services to this population -- schools, child welfare, juvenile justice and substance abuse services. Thus it facilities development of critically needed links among child-serving agencies.

A major goal by FY 1988 is to develop a full continuum of mental health services for children/youth and their families. Increased budget and staff will permit expansion of services, and missing components will be put into place. This will ensure alternatives to hospitalization and a capacity to treat children/youth in the most clinically appropriate, least restrictive settings. Exhibit 3 summarizes planning targets for programs in the new child/youth system.

The new child/youth system will be family-centered. It will involve families in the planning and implementation of a child's treatment. There will be a new emphasis on providing services in the home, both to allow maximum family participation and to help families remain together during times of crisis.

Exhibit 2: Child/Youth Services Administration
District Mental Health System

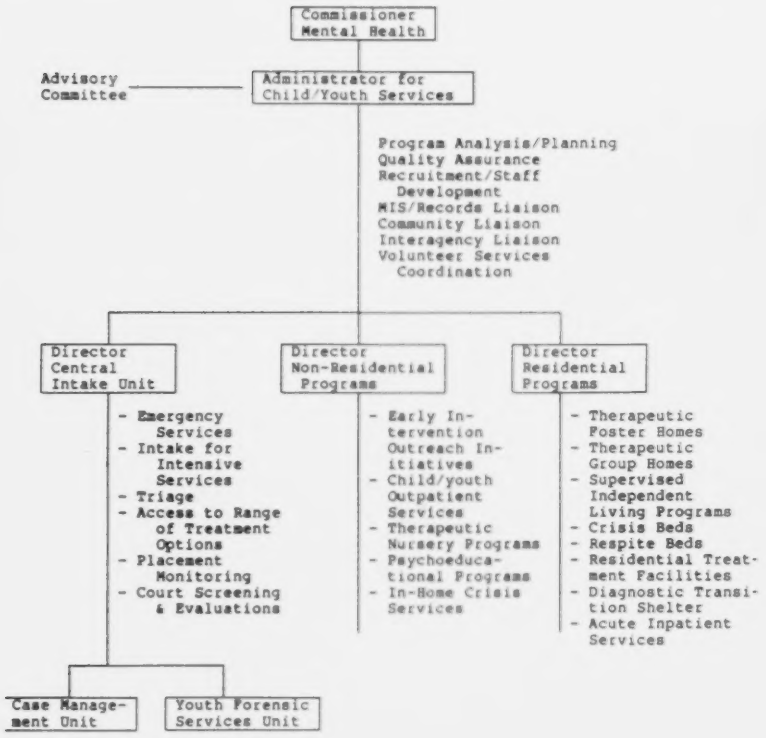


Exhibit I

Program Components, Child/Youth Services Administration:
Planning Targets

| Component | # Child/youth Served in FY'84 By Public Mental Health (MHSA & SEH) | Size of Component in FY '84 | Est. # Child/youth Served in FY'88 | Size of Component in FY '88 | Est. # of Child/youth Served in 1991 | Size of Component in 1991 |
|---|---|---|---|---|---|---|
| Outpatient Services (including C&E, Early Intervention & Outreach, Screening & Assessment, Diagnostic Evaluation, Treatment) | 953 | 3 clinics 35 staff | 1,700 | 3 clinics 55-60 staff | 5,000 | 4+ clinics 130-150 staff |
| Therapeutic Nursery Programs | 21 | 1 program | 50 | 3 programs | 130 | 9 programs |
| Psychoeducational/Day Treatment Programs | 145 | 4 programs | 200-230 | 7 programs | 400-450 | 13 programs |
| Therapeutic Foster Homes | x | x | 20-25 | 8-10 homes | 135 | 45 homes |
| Therapeutic Group Homes - Low Management | x | x | 20 | 2 homes | 100 | 12 homes |
| Therapeutic Group Homes - High Management | x | x | 18-24 | 3 homes | 100 | 14 homes |
| Supervised Independent Living | x | x | 6 | 2 programs | 30 | 9 programs |
| Respite Beds | x | x | 50 | 2 beds | 50 | 2 beds |
| In-Home Crisis Services | x | x | 50-60 families | 2 teams | 150 | 6 teams |
| Diagnostic Transition Shelter | x | x | 60 | 1 program | 60 | 1 program |
| Crisis Beds | x | x | 50 | 2 beds | 50 | 2 beds |
| Residential Treatment Facilities | x | x | 24 | 1 facility | 48 | 2 facilities |
| Acute Inpatient Services | 168 | 32 beds | 160 | 32 beds | 200 | 40 beds |
| Vocational Rehabilitation Services | N/A | N/A | 380 | Linkage to RSA | 1,200 | Linkage to RSA |
| Central Intake Unit | x | x | 500 | 1 team 1 shift | 1,300 | 2 teams 2 shifts |
| Emergency Services | 147 | CRU/EPS | 170 | * * | 200 | * * |
| Service Management Unit (Most intensive case management services) | x | x | 240 | 12 service managers | 350-400 | 20-25 service managers |

* Indicates Component Did Not Exist in FY' 84.

There will also be an emphasis on early intervention and outreach. As a priority during the reorganization period, the system will develop teams of mental health professionals to work with youngsters and staff in the public schools, day care centers, maternal and child health clinics and in the delinquency, neglect and substance abuse systems.

Since most children do not require services more intensive than outpatient treatment, the majority of youngsters will enter the system through child/youth outpatient clinics. These clinics will be located in areas of the city with concentrated need and in settings such as neighborhood health clinics that reduce stigma, encourage regular attendance and foster interaction with other primary care providers. Three clinics will be in place by FY 1988 with sufficient staff to serve 1,700 children/youth and their families over the course of a year and to provide the outreach teams to other agencies.

Some children/youth will gain access to services through a new Central Intake Unit that will control and monitor admissions to intensive treatment settings (psychoeducational, residential and inpatient programs). The Central Intake Unit will provide centralized emergency services, triage and access to a range of treatment options. It will have a Case Management Unit, so that youngsters involved with multiple agencies and programs can be assigned full-time case managers. By FY 1988, the Central Intake Unit will have sufficient staff to handle 500 children/youth a year and will have 12 case managers for about 250 youngsters. The Central Intake Unit also will house the Youth Forensic Services Unit, which will be strengthened in FY 1988 to provide screenings and evaluations for the courts and case liaison and advocacy for court-involved youth. As a priority, the functions of the Central Intake Unit will be developed in coordination with D.C. Public Schools, the Commission on Social Services, the Commission of Public Health and the D.C. Superior Court.

Whether they enter the system through the outpatient clinics or through central intake, children/youth will have individual treatment plans that will be monitored through ongoing, regular case conferences coordinated with other systems in which a child may be involved.

In addition, services will be developed during the reorganization period that are accessible to deaf children and youth and to the Hispanic community. A Mother-Infant Development Program will target children of the mentally ill.

Interagency coordination among child-serving agencies and the involvement of the private sector are both critical to the effectiveness of the new system. Both will be immediate priority objectives.

The Child/Youth Services Administration will also emphasize development of standards, quality assurance supported by an effective management information system, consistent on-site monitoring and ongoing training and staff development.

## Adults

The Adult Services Administration will give priority to persons who are chronically mentally ill. The goal of the administration will be to ensure that persons receiving care move from one stage of treatment to the next and that the legal, financial and organizational barriers which now so often work against such movement will be eliminated.

Services will be centrally managed and monitored to be sure that the quality of care is consistently high and that policy goals are met but that services are readily available in all parts of the city through four mental health service areas created by combining four sets of adjacent wards, one and five, two and eight, three and four, and six and seven. Exhibit 4 illustrates the Table of Organization and Exhibit 5 illustrates the map of service areas.

The public mental health system currently serves nearly 7,000 adults annually, with about 4,000 patients in active treatment at any given time. About 2,900 adult non-forensic patients are admitted to Saint Elizabeths each year and served in a capacity of over 1,200 beds.

EXHIBIT 4
District Mental Health System
Adult Services Administration

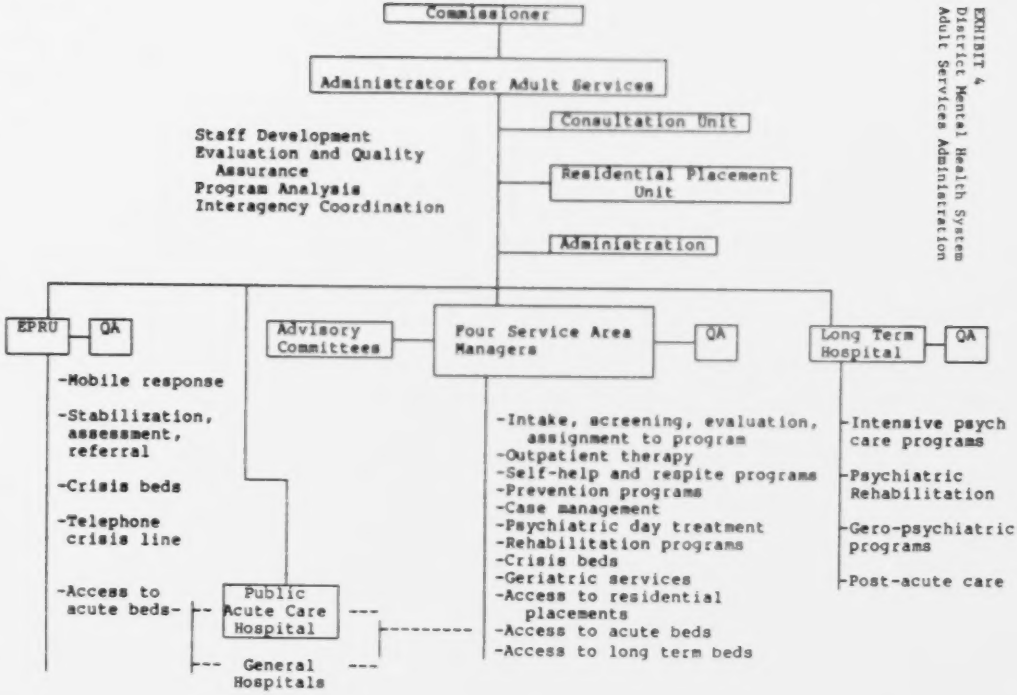


EXHIBIT 5

**Proposed Boundaries of Adult Mental Health Service Areas**

-16-

This plan gives priority from 1986 to 1988 to shifting resources from inpatient to outpatient care. Successful treatment programs now in place will continue, but services will be strengthened to underserved groups such as adult chronic patients being cared for by their families, the homeless and the elderly.

The plan targets 4,500 people in active outpatient care by 1988. About 2,000 of the the more seriously or chronically ill will be in intensive day psychiatric programs, psychosocial rehabilitation programs, psychotherapy or supported residential programs. They will be assisted by case managers to establish permanent community living arrangements and support networks that will enable them to function independently. Day programs will be intensively staffed with psychiatrists, psychologists, nurses, social workers and clinical support services. Crisis beds will expand from 10 to 34. New laboratory and pharmacy services will be initiated. Respite services for the families of the mentally ill and demonstration programs for supported residential programs in which families participate will be organized. These program targets are displayed on Exhibit 6.

It is this intensive concentration of resources on chronically mentally ill people in the community, together with new procedures to assure continuity of care, that will reduce hospital readmission rates by 30-50 percent.

One of the major goals of the adult program will be to foster and develop the healthy aspects of the individual. Patients will be encouraged to participate in selecting their treatment program, in formulating treatment goals and in taking on roles that require responsibility. The dependency needs of those with severe psychiatric disorders will best be met by stable programs and reliable therapeutic alliances that offer consistent emotional encouragement. Programs will allow members to meet in groups that are small enough to retain a family type atmosphere.

Emergency services will be strengthened, with two psychiatrists on duty 24 hours a day. Although no change in the criteria for hospital admission is anticipated at this time, modification of the current mental health law, the D.C. Hospitalization of the Mentally Ill Act, or Ervin Act, D.C. Code §210501 et seq. may be sought if necessary to permit the community psychiatric professional to authorize emergency hospitalization without a second review at the hospital. Outreach to those in crisis, whether they are homeless or with their families, will be expanded. Teams will visit most shelters at least weekly to provide direct mental health services and to work with homeless persons until they can join regular programs.

Exhibit 6

**AMBULATORY SERVICES TO ADULTS**
**PUBLIC MENTAL HEALTH SYSTEM**

| | 9/30/84 | 1988 | 1991 |
|---|---|---|---|
| **Caseload projections** | | | |
| Outpatient | 2,777 | 2,500 | 4,500 |
| Intensive treatment | 1,230 | 2,000 | 5,000 |
| On rolls (active) | 4,000 | 4,500 | 9,500 |
| **Types of treatment** | | | |
| Outpatient therapy | n/a | | |
| Case management (direct) | 0 | 1,800 | 1,800 |
| Service management (includes case management) | 50 | 200 | 3,200 |
| Intensive day treatment | | | |
| Direct | 0 | 120 | 120 |
| Contract | 0 | 120 | 120 |
| Psychosocial Programs | | | |
| Direct | 894 | 600 | 600 |
| Contract | 286 | 600 | 600 |
| Crisis beds | 8 | 34 | 34 |
| Respite care (hours) | 0 | 5,000 | TBD |
| Hispanic program | | | |
| Outpatient | 50 | 300 | TBD |
| Day treatment | 50 | 50 | TBD |
| Hearing impaired program | 0 | 40 | TBD |
| Socialization programs | 81 | 200 | 300 |
| **Housing support programs** | | | |
| In group homes | 600 | 850 | 900 |
| In apartments | 80 | 230 | 547 |
| | 680 | 1,080 | 1,347 |

Acute psychiatric inpatient care will be available in both public and private facilities. Of the projected need for 215 publicly supported acute beds, nearly half will be at Saint Elizabeths Hospital. The rest will be available in general hospitals through contractual arrangements. One of the advantages of using general hospitals will be the increased availability of Medicaid funds to pay for the treatment.

The long-term hospital will be reorganized into programs of different treatment levels and modalities according to the needs of patients, with specific programs for the elderly mentally ill.

Two new programs will be established in facilities on the Saint Elizabeths grounds for nearly 140 patients now in the psychiatric hospital who are ready for nursing care and for another 150 who are mentally retarded as well as mentally ill. By transferring these patients out of the psychiatric hospital, and by reducing hospital admissions through stronger follow-up and community care, the size of the adult non-forensic hospital will be reduced from over 1,200 to 430 beds. In this way, funds will be available to shift to outpatient programs, children's services and services in the jail.

More than 300 persons at Saint Elizabeths Hospital who are ready for community living will be placed in supported or supervised residential programs. There are now about 600 mentally disabled persons living in supervised homes and apartments in the District. There are about 700 more who should be -- about 300 Dixon patients still at Saint Elizabeths Hospital, 200 homeless persons who are also mentally ill and 200 individuals who have been independent but now need assistance. The cost to the community of maintaining a person in the community is about $16,000 a year, but if that person is a resident at Saint Elizabeths Hospital, the cost is at least $65,000. There is often neighborhood resistance to housing for the mentally disabled, but these barriers can be overcome. New community homes for about 115 persons a year in each of the six transition years will be necessary. To accomplish this goal there will be a housing development unit at the highest level in the system. New strategies for supporting community living will include a legislative proposal to extend the SSI board and care supplement to persons living in apartments as well as group homes, new regulations ensuring adequate supervision of group homes for mentally disabled persons, development of structured programs and case management connected to housing support, stimulation of low-income rental assistance for the disabled, and new programs to encourage foster family participation in the care of the mentally ill.

Once this fundamental shift of resources is under way, the priority of the adult service system can shift to increasing outreach to more chronically ill persons and their families and to further exploration of new approaches to care through physician provider groups, HMOs or other service management arrangements.

## Mentally Ill Offenders

Like programs for children/youth and adults, the program of mental health services to those in the criminal justice system will be centralized in a Forensic Services Administration. The forensic program will consolidate services now provided by the District's Bureau of Forensic Psychiatry and the John Howard Division at Saint Elizabeths Hospital.

There will be a single point of accountability for services to the Federal District Court and the D.C. Superior Court (including evaluation of a person's competency to stand trial or the restoration of his or her competency). That division will have the capacity to provide 865 competency screenings a year, 1,000 competency examinations and 200 pre-sentencing and probation consultations.

Another division will assist the Corrections Department to screen for mental illness 3,500 persons a year in the jails and to provide crisis and intermediate care to detainees and prisoners. Attention will be given to ensuring that those leaving the criminal justice system are linked to the District's regular mental health service program.

A forensic hospital of about 370 beds will be available on the Saint Elizabeths campus for inpatient evaluations or to treat those found incompetent to stand trial or not guilty of crimes by reason of insanity.

Homeless People and Others in Need of Specialized Help

Clinical teams will reach out in more effective ways to those who normally would not seek care, a population which includes people who are both homeless and mentally ill, refugees from other countries who are reluctant to seek care because of cultural and language barriers or because they are in this country illegally and people who find mental health services inappropriate to their values and culture. They will do this, in part, by identifying the barriers that prevent people from receiving care and finding ways to overcome them. The effectiveness of these outreach programs will periodically be examined.

There are now an estimated 5,000 homeless individuals in the city, with about 2,250 persons in shelters during the worst winter months. Recent studies indicate that about one-quarter of the homeless men and one-third of the homeless women previously have been in a hospital for the mentally ill. In providing care to homeless people who are mentally ill, the new mental health program will use non-traditional techniques but will extend services in a manner consistent with the protections of the rights of the mentally ill provided by the Ervin Act. Mental health personnel will go into the shelters and work with homeless people who are in need of mental health care until they can join regular programs. Long-term solutions will be pursued such as single room occupancy (SRO) living accomodations that afford the individual considerable freedom but require participation in a day treatment program or a therapeutic hostel for seriously mentally ill homeless individuals providing long-term care in a protected environment. A coordinator of programs for the homeless will be located at the highest level of the system to be sure that program goals are met.

In addition, there will be special programs of care for the mentally retarded who are also mentally ill, for Hispanic and other cultural minorities, for persons who in addition to suffering from emotional or mental illness also misuse drugs and alcohol and for those whose physical handicaps, such as hearing impairment, prevent access to services.

## Other Programs

A new mental illness **prevention** program will focus on activity that forestalls psychiatric problems and strengthens people's capacity to live independent, productive lives. Designed to help people help themselves, it will include health promotion, accomodation to life stress situations and intensive intervention to high risk individuals and families. Priority groups will include those who are unemployed, single mothers who have low incomes the elderly and the children of people who are mentally ill or unemployed.

There will also be a strong **patient advocate** program to protect patients' rights. The various communities throughout the city will be involved in planning and oversight of the new system through formal **advisory committees.**

**Research** into the causes of and solutions to mental illness currently underway at Saint Elizabeths Hospital under the auspices of the National Institute of Mental Health will continue. The District will sponsor additional research efforts pertinent to the needs of those mentally ill persons who live in our community.

In addition to the intensive in-service **training programs** which will continue throughout the transition, the District's mental health system will seek to continue the pre-service residencies and training opportunities to develop the skilled professionals needed in modern, high quality mental health programs. Several issues remain to be worked out, however. One is a question of management. The present graduate programs are managed internally by Saint Elizabeths Hospital. The District's mental health system could seek accreditation to continue such an independent arrangement or could seek affiliation with one or more of the local teaching hospitals to manage the program. Equally important is the question of the source of funds for residencies and stipends to trainees. The federal government now supports over 30 psychiatric residents annually and their faculty and supervisors at Saint Elizabeths Hospital. Because the resources of the District mental health system will be fully stretched to accomplish its demanding service delivery requirements,

and in view of the national importance of continuing training opportunities for minority professionals in public psychiatry in settings which have such an outstanding track record in this regard, the District will seek a continuation of that federal support.

A new **quality assurance and program evaluation system** will be initiated to monitor meaningful patient outcome criteria. Visits to the emergency psychiatric unit, hospitalizations, program dropout rates and other data will be monitored in both public and private programs. Effective programs will be expanded and enhanced while ineffective programs will be dropped. Drug profiles, laboratory data, patient movement and other information will be computerized so that the effectiveness of treatment can be measured.

The importance of automated data systems in meeting the policy goals of the plan cannot be overemphasized. A **comprehensive information system** and data base for effective program support and efficient management of resources are already under development. Special emphasis will be placed on protecting the patient's right to privacy while providing administrators and clinicians with information that will be useful in planning and assessing services. The ADP system will support a variety of clinical and administrative functions, including: strategic planning, program evaluation and research; client tracking to assure linkages among service components; clinical management; pharmacy and laboratory services; quality assurance; billing and accounting and personnel management.

## MENTAL HEALTH SYSTEM STAFF

The newly created Commission on Mental Health will need about 2,300 public employees to deliver these programs. About 300 to 400 additional employees will be needed in other support agencies such as the Office of Personnel and the Department of Public Works.

Clinical staff requirements in the comprehensive system are based on the development of staffing patterns for each component of the system. The staffing standards meet or surpass the requirements of the Dixon Plan and Joint Commission on the Accreditation of Hospitals consolidated standards.

Services to 4,500 adult patients will be staffed at an overall outpatient staff to patient ratio of 1:28 and a ratio of 1:7 for day treatment. Case management workloads will average 1:40. Central staff for clinical support programs will be available to outpatients as well as will the on-site medical and pharmacy staff. The acute, long-term and forensic hospitals will have a staffing ratio of 1.2:1, although different programs will have different mixes of staff.

Staff to patient ratios for child and youth programs will range from 1:14 in clinical outpatient programs to 1:3 in psychoeducational programs to 1.5:1 in therapeutic group homes to 1.8:1 in the acute inpatient program.

In accordance with P.L. 98-621, the maximum use of Saint Elizabeths Hospitals employees will be made in staffing the new mental health system. The law spells out the method by which all new positions in the District's mental health system and in other District agencies providing support services will be offered to Saint Elizabeths Hospital employees prior to October 1, 1987. In addition, all new mental health support contracts to be funded in FY 1988 will require that Saint Elizabeths Hospital employees be given the right of first refusal for all new positions created under those contracts.

In general, the new Commission on Mental Health and related support agencies will require significantly fewer positions than the combined Mental Health Services Administration and Saint Elizabeths Hospital total of approximately 3,650 employees.

This is true for two major reasons: first, the number of hospital beds will be reduced by about half. This is made possible by the transfer of patient care to general hospitals, to residential care, to a new nursing home program and to a new program for those who are mentally retarded as well as mentally ill. Saint Elizabeths Hospital employees will be offered positions in the hospital and new nursing level facilities and in new outpatient programs.

Second, because the facilities of the system will be consolidated into half as many buildings and acres as at present, the staff necessary to maintain those facilities and grounds will be reduced. Should the proposal for the remainder of the site, which will be put forth at a later time, call for public support staff, an additional number of jobs will be offered to Saint Elizabeths Hospital employees.

Exhibit 7 displays the overall impact of this reorganization plan on Saint Elizabeths Hospital employees. It should be noted that a far larger number of employees will be eligible for retirement or early retirement than the largest estimate of displaced employees. Nevertheless, any employees who may be displaced will be entitled to assistance under the provisions of P.L. 98-621 that create a Displaced Employee Program and give priority access to all vacancies in the District's Department of Human Services, D.C. General Hospital and in the metropolitan offices of the U.S. Department of Health and Human Services through October 1, 1989.

Exhibit 7

**ESTIMATED IMPACT OF REORGANIZATION ON STAFF RESOURCES**

| | Low Estimate | High Estimate |
|---|---|---|
| Total positions Mental Health Commission | 2,300 | 2,500 |
| Less existing MHSA positions | 300 | 300 |
| Equals new Mental Health Commission positions | 2,000 | 2,200 |
| Plus new positions other agencies | 300 | 400 |
| Plus positions available through new contracts* | 550 | 550 |
| Plus West side options | 0 | 200 |
| Equals total new positions to be offered | 2,850 | 3,350 |
| Existing SEH employees | 3,348 | 3,348 |
| Difference | -498 | +2 |
| SEH employees eligible for early retirement | 1,000+ | 1,000+ |

* Contracts for acute psychiatric, nursing home, ICF/MR, youth residential programs, day treatment programs, laundry and dietary services.

## MENTAL HEALTH SYSTEM FACILITIES

The present facilities of the combined mental health systems include 336 acres and more than 100 buildings at Saint Elizabeths Hospital as well as four major District-owned facilities used for community mental health care.

The new mental health system will retain the current community facilities, establish some satellite programs in the community and use one-half of the present Saint Elizabeths Hospital grounds. The old, but partially renovated, buildings at the hospital will be the locus of the public hospital and intermediate care hub of the comprehensive mental health system, along with some transitional facilities for those patients who can benefit from being closer to the well staffed programs on the hospital's grounds.

The East side of the site will be reorganized as a multipurpose complex, as illustrated in Exhibit 8. There will be about 830 beds for inpatient hospital care, organized into three distinct parts: a forensic hospital of about 370 beds, a long-term psychiatric hospital of about 300 beds and an acute care psychiatric hospital with 100 beds for adults, 32 beds for children and adolescents and a 30-bed unit for the deaf mentally ill. Also within the complex will be about 140 nursing care beds, 150 beds for mentally retarded persons who are also mentally ill and 141 transition residential beds. The total will be about 1,300 beds.

This consolidation of facilities will achieve a much more economical plant for the mental health system. Nevertheless, the condition of the buildings and utility systems requires considerable capital investment to meet reasonable or even minimum safety and efficiency standards.

In 1976, Congress authorized a $66-million capital renovation program, of which about $10 million remains to be obligated. **The cost of this capital program has been borne almost entirely by the District government through its share of debt service.** The intent of the capital construction plan was to renovate to accreditation standards a limited number of patient care buildings to hold 1,700 beds. Much of the $56 million already spent was allocated to the renovation of temporary buildings while the major buildings were under reconstruction and to fund ongoing repair and maintenance needs of the entire site over the last decade. Construction costs

EXHIBIT 8

CURRENT AND PROJECTED BEDS
D.C. MENTAL HEALTH SYSTEM

| Type of Service | Public Psychiatric Hospital | | | New Other Agencies 1988 | | | New CMH 1988 | | |
|---|---|---|---|---|---|---|---|---|---|
| | 10/30/84 | On Campus 1988 | Change | On Campus | Off Campus | Change | On Campus | Off Campus | Change |
| Forensic | 348 | 372* | +24 | | | | | | |
| Child/Adoles. | 33 | 32 | 0 | | | | | | |
| Deaf | 30 | 30 | 0 | | | | | | |
| Research | 30 | 0 | -30 | 30 | | +30 | | | |
| Psychiatric Inpatient | 323 | 300 | -23 | | | | | | |
| Nursing | 238 | 0 | -238 | 138 | 100 | +238 | | | |
| Mental Retard. | 150 | 0 | -150 | 150 | | +150 | | | |
| Residential | | | | | | | | | |
| Adult | 316 | 0 | -316 | | | | 141 | 255 | +396 |
| Children | 0 | 0 | 0 | | | | 0 | 80 | +80 |
| Acute | 176 | 100 | -76 | | | | | 76 | +76 |
| Total | 1644 | 834 | -810 | 318 | 100 | 418 | 141 | 411 | +552 |

*Includes 24 beds transferred from Ugast Center

costs have of course significantly risen over the decade. At present eight buildings with 631 beds have been completed. When current projects are complete, a total of about 1,200 beds will have been renovated. The remaining $10 million could not renovate more than an additional 200 beds at most. Thus the original Congressional commitment to a renovation of 1,700 cannot be achieved within the existing authorization.

In addition, major repairs or renovations to the plant are still required, including needed replacement of much of the steam plant and its underground pipes. Additional funds will be necessary to meet the obligation of the federal government to bring all transferred buildings up to code compliance, a cost which is to be established by the facilities audit currently under way.

Altogether, a preliminary independent engineering study conducted in 1985 under the supervision of national psychiatric experts determined that the capital investment required to meet reasonable modernization and professional standards for the consolidated east side of the grounds would be approximately $44 million.

Although Congress made no provision in P.L. 98-621 for renovation funds beyond a limited obligation to maintain code compliance in the transferred buildings, this plan is based on the following four objectives with respect to capital needs:

First, the federal government should target the remaining $10-11 million in capital authority to renovation of buildings to be used for patient care.

Second, the complete cost of current critical maintenance and repairs should be funded by a new federal capital appropriation intended solely for that purpose.

Third, the cost of any renovation needed to meet the code compliance provisions of P.L. 98-621 should be undertaken through a new capital appropriation intended solely for that purpose.

Fourth, the District government will seek federal financial support for the additional $34 million in capital needs for the East side of the grounds. This will permit completion of the original intent of the Congressional capital authorization.

With respect to the West side of the site, under the terms of P.L. 98-621, the Mayor may, upon determining the need for buildings on the Saint Elizabeths Hospital campus for mental health and related human services, propose a master plan for any remaining portion of the grounds. This draft preliminary plan addresses only those mental health system needs which will occupy the East side of the campus. In subsequent drafts of this plan, proposals for mixed uses on the West side of the campus will be addressed.

## MENTAL HEALTH SYSTEM FISCAL RESOURCES

In planning the reorganization of the comprehensive mental health system, the boundaries established by the District's multiyear financial planning targets have been observed (See Exhibit 9.) As a result, the total budget for FY 1988, to which the staff and facilities resources of the preliminary system implementation plan are directed, must not exceed $162 million.

These expenditures must include the one-time base budget transfers which will accompany the transfer of patients and staff to other agencies, for Medicaid payments to general hospitals, and for nursing care, joint programs for the mentally retarded/mentally ill, and support programs, as well as one-time transfers into the mental health system of other responsibilities. The net impact of these transfers is expected to be about $31.5 million. Thus the budget of the Mental Health Commission must be no more than $129.6 million.

Preliminary projections indicate that the program and staffing targets for FY 1988 outlined in this plan, which will carry out the policy goals of transferring resources from long-term inpatient care to outpatient care for adults, a new continuum of care for children and youth and enhanced forensic evaluation and treatment programs, can be accomplished within this $129.5 million mark. The ability to stay within this target, however, is contingent on the system's ability to shift resources from inpatient care to other programs. Failure to do so will result in a significantly higher level of expenditure.

Over the 1989-1991 transition period, the system must carry out rigorous cost controls and identify additional efficiencies to counteract inflation and stay within the 1991 target.

During the six-year transition, the District will need to increase its appropriated funds for mental health care from about $60 million to over $100 million to replace the declining federal appropriation and transition subsidy. This overall impact on the District's budget gives added importance to the proposal contained in this plan for continuing federal financial participation in two critical areas: an additional $34 million in capital renovation costs and up to $4 million in training costs. Both issues are closely interwoven with the historic role of Saint Elizabeths Hospital in mental health care and will be further discussed with federal officials.

More detailed budget projections will be presented in the final plan which will follow public and legislative review of the goals and structure of the new system.

EXHIBIT 8

ESTIMATED MENTAL HEALTH SYSTEM BUDGET
(in millions)

| | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | | | | | | |
| Appropriated | | | | | | | | | | | |
| District | | | | | | | | | | | |
| Mental Health Services Administration | 13.0 | 11.4 | 12.2 | 12.9 | 15.7 | 19.6 | 23.3 | (UNIFIED BUDGET) | | | |
| St. Elizabeths Payment | 21.3 | 22.9 | 24.7 | 35.2 | 55.2 | 63.0 | 71.2 | | | | |
| Sub-Total District | 34.3 | 34.3 | 36.9 | 48.1 | 70.9 | 82.6 | 94.5 | 103.3 | 77.8 | 83.8 | 89.8 |
| (Federal Subsidy) | | | | (5.0) | (20.0) | (25.0) | (35.0) | (30.0) | (20.0) | (15.0) | (10.0) |
| Federal | | | | | | | | | | | |
| DHHS-St. Elizabeths | 96.6 | 95.7 | 81.0 | 69.8 | 48.6 | 42.5 | 36.0 | 30.0 | 24.0 | 18.0 | 12.0 |
| Total Appropriated | 130.9 | 130.0 | 117.9 | 117.9 | 119.5 | 125.1 | 130.5 | 133.3 | 101.8 | 101.8 | 101.8 |
| Other revenue | 7.2 | 6.7 | 29.9 | 24.1 | 24.7 | 24.8 | 26.7 | 27.8 | 27.8 | 27.8 | 27.8 |
| Total | 138.1 | 136.7 | 147.8 | 142.0 | 144.2 | 149.9 | 157.2 | 161.1 | 129.6 | 129.6 | 129.6 |
| **EXPENDITURES** | | | | | | | | | | | |
| Mental Health System | | | | | | | | 129.6 | 129.6 | 129.6 | 129.6 |
| Related Services | | | | | | | | | | | |
| Reorganization Office | ---- | ---- | ---- | ---- | 1.0 | 1.0 | 1.0 | ---- | | | |
| Long Term Care | ---- | ---- | ---- | ----* | ----* | 1.2 | ---- | 5.0 | | | |
| Mental Retardation | ---- | ---- | ---- | ---- | ---- | ---- | ---- | 6.0 | | | |
| Public Works & Other Support** | ---- | ---- | ---- | ---- | ---- | ---- | ---- | 20.5 | | | |
| Total*** | | | | | 1.0 | 2.2 | 1.0 | 31.5 | | | |
| Total | 138.1 | 136.7 | 147.8 | 142.0 | 145.2 | 152.1 | 158.2 | 161.1 | | | |

* Major increases in nursing care and drug program transfer took place in 1984 and 1985 budgets.
** Includes cost of services such as Fire, Security, & Buildings & Grounds Maintenance, which will be transferred to other D.C. Government Departments.
*** Increases in FY 1989 and later years to be covered within the base budgets of non-mental health system agencies.

## TRANSITION IMPLEMENTATION

The goals of this plan are both exciting and ambitious. Implementing a reorganization of this complexity and scope requires vigorous leadership, thorough training programs and dedicated resources during the transition period. It also requires a careful and detailed timetable of specific actions.

The plan is framed by two critical dates:

The first is the date of assumption of responsibility for all patient care by the District government on October 1, 1987.

The second is the end of the transition period on October 1, 1991 by which time the District's comprehensive mental health system must be fully in place.

**This plan is based on the accomplishment of certain key goals prior to the assumption of District responsibility on October 1, 1987.**

To accomplish these goals, the Department of Human Services will create immediately a Reorganization Implementation Team, chaired by Director David Rivers. Senior executives of Saint Elizabeths Hospital have agreed to work with senior executives of the Department of Human Services in this structure.

This team, meeting biweekly throughout the transition period, will review ongoing management decisions affecting the combined mental health system to ensure that daily operations are closely coordinated and consistent with reorganization goals. The team will also develop a detailed work plan for activities prior to October 1, 1987. The Mental Health System Reorganization Office will act as staff for the team. Task groups of District and federal officials will be formed for each activity and will ensure that patients and staff affected by the changes participate in both planning and implementation.

The provisions of P.L. 98-621 which allow Saint Elizabeths Hospital staff to be detailed to the District mental health organization will be used to begin implementing the plan in close consultation with District Council and Congressional officials responsible for review of the plan.

Many significant changes must be implemented prior to October 1, 1987, including:

- o combining and reorganizing adult outpatient services. Actual transfer of patients and staff will be staged over the two-year period to avoid disruption of patient care.

- o combining and reorganizing emergency psychiatric services and services to the homeless.

- o reorganizing hospital facilities at Saint Elizabeths into an acute care hospital with specialized units for children and for the hearing impaired, a long-stay hospital and nursing and residential facilities.

- o reorganizing and centralizing services for children and youth.

- o reorganizing forensic evaluation services and mental health services in the jails based on development of careful procedures and new standards.

- o developing a detailed capital renovation program for the East side of the campus, preparing architural and engineering plans and developing a financing plan to extend and complete the existing capital authorization.

- o consolidating the two management information systems into a single integrated data base and uniform functions; initiation of a five year ADP plan for the comprehensive mental health system.

- developing detailed job and function descriptions for each component of care.

- continuing the detailed joint planning of personnel actions required to implement the personnel provisions of P.L. 98-621 and an extensive information and consultation program for all employees to ensure that their rights and benefits are fully protected during the transition period.

- conducting intensive staff training and development activities to ensure that every employee in the comprehensive system has the opportunity to participate in the development of the new system and to become fully effective within the new structure.

- developing Certificate of Need applications for major facilities.

- implementing the patient advocacy structure and the citizen participation provisions of the plan.

- consulting with the Joint Commission on Accreditation of Hospitals in preparation for the necessary survey in FY 1988.

- negotiating agreements with general hospitals to provide acute psychiatric care funded by Medicaid or other public funds.

- establishing pilot projects which combine residential, treatment, support and case management services with the participation of families of the mentally ill.

- developing the systemwide quality assurance and program evaluation system.

A detailed set of such activities, objectives timetables will be developed by the reorganization implementation team beginning in November 1985. These will include every activity necessary to accomplish the FY 1988 goals of this reorganization plan so that the formal implementation date of October 1, 1987, will be orderly and effective for patients, families and staff.

The first phase of transition from 1986 to 1988 concentrates on the massive reallocation of resources, on intensive reclassification of patients and program levels and on development of new written procedures and standards throughout the new mental health system. The second phase will consolidate these changes, continue intensive staff training, complete the necessary facility renovations and reach out to serve more persons in the District more effectively.

## Transition Issues

The reorganization plan will require tremendous energy and commitment by all those engaged in mental health service delivery in the District.

The experience of other states and cities throughout the country cautions us about the challenge of what we propose. Although community-based care has been the goal, state mental institutions have retained most of the money. Without investment in community treatment, residential and support programs, chronically ill patients are lost to the streets and the jail, and the families of the mentally ill suffer extraordinary burdens.

This reorganization plan emphasizes and puts resources behind these ingredients of a successful transition:

- establishment and reinforcement of clear policy goals and a specific timetable to achieve them
- continued involvement in transition planning and implementation of all those affected by it
- management of "start up" and "phase down" activities by the Reorganization Implementation Team coordinating both development of community resources and maintainance of quality inpatient services
- development of employee transfer opportunities, career ladder mobility, training and attention to employee morale during the transition period
- strengthening of vendor contracts to ensure accountability and enforcement of performance standards

- development of strong and detailed agreements with other program agencies (mental retardation, public health, substance abuse, public schools, vocational rehabilitation and family and youth services) and system support agencies (public works, administration and personnel).

Nevertheless, two overarching challenges remain:

**One is to forge community understanding and support for comprehensive mental health care.** This task goes far beyond the reorganization plan itself. It requires the ongoing education of all District residents about the importance of mental health, about the causes of mental illness and about the need for community acceptance of all those who are disabled as neighbors and fellow citizens.

**The other is to integrate the many constituencies of mental health care into a unified force for successful change:**

patients and ex-patients who can take responsibility not only for their own lives but also for helping each other and for influencing the course of change

families who through their local organization have already played a leading role in helping to develop this plan and can be a critical part of building wider support and education

employees whose skill and dedication to demanding tasks must be recognized and supported throughout the transition

professionals in mental health who can rise above traditional divisions among psychiatrists, psychologists, social workers and nurses to support a system based on effective outcomes for patients with contributions from many skilled workers

community mental health providers including agencies, hospitals and individual providers, who can join a newly integrated network of care for all residents.

Only with the cooperation of patients, families, employees, mental health professionals and community agencies will this plan work. The personnel and the resources are available. All that is needed now is the will and the effort united behind a common purpose.

## PLANNING COMMITTEE

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Director
Department of Human Services

Dr. Andrew D. McBride
Commissioner of Public Health

Audrey Rowe
Commissioner on Social Services

Dr. Gladys Baxley
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Dr. James Collins
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Dr. John F. Borriello
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Ruth Micheaux
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D.C. Mental Health Association

Edith Maeda
Director of the Board
Coalition of Community-Based
Mental Health Facilities

James Kunen
Chairman
Mental Health Law Project

Merion Kane
President
Threshold D.C., Inc.

Dr. Douglas Glasgow
Vice President
National Urban League

Floretta D. McKenzie
Superintendent
D.C. Public Schools

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Chief Judge
U.S. District Court

Honorable Fred B. Ugast
Judge
D.C. Superior Court

### Ex-Officio

Madeline Petty
Director, Department of Housing
and Community Development

**Members of Labor-Management Advisory Committee**

Mr. Raymond Becich
Assistant Superintendent
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Mr. George Bispham
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AFSCME/AFL-CIO, Council 20
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Consumer Forums

Anchor Mental Health Association

Barney Neighborhood House

Coalition of Community-Based Mental Health Facilities

Coalition for the Mentally Ill

Friendship House Psychosocial Rehabilitation Program

Green Door

Mental Health Services for the Homeless

Michaux Senior Center

National Health Care Foundation for the Deaf - Otis/CCHI House

North Community Mental Health Center

Saint Elizabeths Hospital

- Area D Community Mental Health Center
- Comprehensive Alcohol and Drug Abuse Center
- Godding-Noyes Division
- John Howard Pavilion
- John Marr Division
- Mental Health Program for the Deaf
- O'Malley Division

South Community Mental Health Center

## Civic and Advocacy Groups

Adult Protective Services Advisory Council
Commission on Aging
Commission on the Homeless
Coalition for the Homeless
Coalition for the Mentally Ill
Dixon Implementation Monitoring Committee
Friends of Saint Elizabeths Hospital
Information Center for Handicapped Individuals, Inc.
Mental Health Association of D.C.
Threshold Alliance for the Mentally Ill

## Professional Organizations

Ad Hoc Group of Public and Private Psychiatrists
American Psychiatric Association
Association of Saint Elizabeths Hospital Physicians
Black Psychologists of D.C.
D.C. Medical Society
D.C. Medical Society Committee on Aging
District of Columbia Psychological Association
National Association of Social Workers
National Mental Health Association, Executive Board
Saint Elizabeths Hospital Medical Society

## Private Provider Agencies and Organizations

Anchor Mental Health Association
City Lights
Coalition for Communty-Based Mental Health Facilities
Community Connections
Community Residence Facility Association
D.C. Institute for Mental Hygiene
Green Door
Psychiatric Center Chartered
Psychiatric Institute

**Government Officials with Programs Relevant to Mental Health**

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